

**Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment
Parameters for 2014—Final Rule
Summary**

March 21, 2013

On March 11, 2013, the Centers for Medicare & Medicaid Services (CMS) of the Department of Health and Human Services (HHS) published the final rule providing detail and parameters related to certain provisions of the Affordable Care Act (ACA) (see 78 *FR* 15410-155491): the risk adjustment, reinsurance, and risk corridors programs (also known as the Premium Stabilization Programs); cost-sharing reductions; user fees for a Federally-facilitated Exchange; advance payments of the premium tax credit; the Federally-Facilitated Small Business Health Option Program (SHOP); and the medical loss ratio (MLR) program. The final rule is effective on April 30, 2013.

A detailed summary of the provisions of this final rule is provided below. Note that summaries of the Collection and Information Requirements and Regulatory Impact Analysis are incorporated in the relevant sections of the summary.

This final rule covers subjects in 45 CFR Parts 153 through 158. For the most part, it incorporates the provisions of the proposed rule. Those provisions of the final rule that differ from the proposed rule are listed at 78 *FR* 15507-15508. Among the most significant related to the premium stabilization programs are: the addition of a description of the risk adjustment user fees that will be imposed by the Federally Facilitated Exchanges on issuers; modifications and clarifications related to the application of the reinsurance contributions and calculations of plan reinsurance payments; and a clarification that regulatory fees as well as taxes will be subtracted from premiums before calculating risk corridor targets.

CMS adopts most of the proposed rules related to the advance payment of the premium tax credit and cost-sharing reduction programs, but does make several changes. It allows Exchanges greater flexibility in allocating the advance payment of the premium tax credit if one or more individuals in a tax household enroll in more than one policy through the Exchange. CMS also specifies the methodology that will be used for allocating advance payments of the premium tax credit provided through Federally-facilitated Exchanges. It permits HHS to adjust the cost-sharing reduction advance payment if Qualified Health Plan (QHP) issuers can demonstrate during the year that the actual reductions are likely to differ substantially from the advance payments. CMS makes a number of changes throughout the rule to clarify that Multi-State program plans will be following policies and procedures set by the Office of Personnel Management (OPM).

The rule finalizes certain requirements for the SHOPS, including eligibility-related definitions and counting methods regarding small and large employers and full-time employees and allows SHOPS to selectively list only brokers registered with the SHOP. For the Federally-facilitated SHOP, operational features are established, including a 70 percent minimum participation rate. In a separate proposed rule also published on March 11, 2013 (78 *FR* 15553), CMS proposes to

modify previously adopted rules for SHOPs to delay employee choice and shorten special enrollment periods.

With respect to the Medical Loss Ratio (MLR) standards, the final rule requires accounting for risk adjustment and risk corridor payments and receipts as adjustments to the numerator (incurred claims) in calculating the MLR, but treats reinsurance as subtractions from the denominator. CMS also delays the date for paying MLR rebates from August 1 to September 30 and allows tax-exempt issuers to deduct both state premium taxes and community-benefit expenditures for purposes of calculating the MLR, since community-benefit expenses are incurred in lieu of paying federal taxes, which would otherwise be deductible.

| Table of Contents | |
|--|-------------|
| Section | Page |
| I. Background | 2 |
| II. Provisions of the Proposed Rule | 4 |
| A. Provisions of the State Notice of Benefit and Payment Parameters | 4 |
| B. Provisions and Parameters for the Permanent Risk Adjustment Program | 4 |
| C. Provisions and Parameters for the Transitional Reinsurance Program | 28 |
| D. Provisions for the Temporary Risk Corridor Program | 44 |
| E. Provisions for the Advance Payments of the Premium Tax Credit and Cost-Sharing Reduction Programs | 48 |
| F. Provisions on User Fees for a Federally-Facilitated Exchange | 65 |
| G. Distributed Data Collection for the HHS-Operated Risk Adjustment and Reinsurance Programs | 66 |
| H. Small Business Health Options Program | 71 |
| I. Medical Loss Ratio Requirements | 76 |

I. BACKGROUND

In March of 2012, HHS published the *Patient Protection and Affordable Care Act: Standards Related to Reinsurance, Risk Corridors and Risk Adjustment Final Rule* (Premium Stabilization Rule) (77 FR 17220) and the *Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers Final Rule* (77 FR 18310). These rules implement standards for Affordable Insurance Exchanges (Exchanges), states, and health insurance issuers related to the reinsurance, risk adjustment, and risk corridors programs established by the ACA and the establishment of Exchanges and qualified health plans (QHPs). In December, 2012, HHS published the *Proposed Advanced Notice of Benefit and Payment Parameters* (77 FR 73118), which included a number of changes to the regulations related to the premium stabilization programs as well as changes to implementing regulations for certain other provisions of the ACA, including the advance payments of the premium tax credit, cost-sharing reductions, Exchanges, (including the Small Business Health Options Program (SHOP) Exchanges), and Medical Loss Ratio requirements.

On March 11, 2013, CMS also published an interim final rule with comment, the *Patient Protection and Affordable Care Act; Amendments to the HHS Notice of Benefit and Payment Parameters* (78 FR 15541-15552). Among other purposes, this IFR provides for adjustment to the risk corridors calculations to align such calculations with the single risk pool provision that was finalized in the February 27, 2013 Health Insurance Market Rules (78 FR 12406-13492). The risk corridor provisions of this IFR are included in this summary. **Comments are due by April 30, 2013.**

In the final rule’s preamble, HHS reviews the relevant ACA statutory and regulatory history. It notes that HHS, Labor, and Treasury are working in close coordination to release guidance related to Exchanges in several phases. The following table identifies relevant prior regulations and guidance.¹

| ACA Provisions | Prior Regulations or Guidance Date of Publication in the <i>Federal Register</i> |
|--|--|
| Premium Stabilization – Risk adjustment; reinsurance and risk corridors | Proposed rule: July 15, 2011 (76 FR 41930) Final rule: March 23, 2012 (77 FR 17220) Proposed Advance Notice of Benefit and Payment Parameters: December 7, 2012 (77 FR 73118) |
| Risk Adjustment | White paper: September 12, 2011 Bulletin on intended HHS approach to implementing risk adjustment on behalf of a state : May 31, 2012 Public Meeting: May 7-8, 2012 |
| Reinsurance | Bulletin on intended HHS approach to implementing reinsurance program on behalf of a state: May 31, 2012 |
| Cost Sharing Reductions | Bulletin on intended HHS approach to calculating actuarial value and implementing cost-sharing reductions: February 24, 2012 |
| Advance Payments of the Premium Tax Credit | Proposed Rule: August 17, 2011 (76 FR 50931) Final Rule: May 23, 2012 (77 FR 30377 or 26 CFR 1 and 602) |
| Exchanges | Request for Comment: August 3, 2010 (75 FR 45584). An Initial Guidance to States on Exchanges: November 18, 2010 Proposed Rule: July 15, 2011 (76 FR 41866) Proposed Rule re: specific functions in the individual market, eligibility determinations, and Exchange standards for employers: August 17, 2011(76 FR 51202) Final Rule on establishment of Exchanges: March 27, 2012 (77FR 18310) Proposed rule on eligibility, hearing and appeals provisions: January 22, 2013 (78 FR 4594) |
| Market reform rules | Proposed Rule: November 26, 2012 (77 FR 70584) Final Rule: February 27, 2013 (78 FR 13406) |
| Essential Health Benefits and Actuarial Value | Proposed rule: November 26, 2012 (77 FR 70644) Final Rule: February 25, 2013 (78 FR 12834) |
| Medical Loss Ratio | Request for Comment: April 14, 2010 (75 FR 19297) Interim Final Rule with Comment Period: December 1, 2010 (75 FR 74864). Interim Final Rule with Comment Period: December 7, 2011 (76 FR |

¹ The table was prepared by Health Policy Alternatives based on the text of the final rule.

| ACA Provisions | Prior Regulations or Guidance Date of Publication in the <i>Federal Register</i> |
|----------------|---|
| | 76596) Final rule with Comment period : December 7, 2011 (76 FR 76594) Final Rule: May 16, 2012 (77 FR 28790) |

II. PROVISIONS OF THE PROPOSED RULE

HHS received approximately 420 comments from a wide range of stakeholders in response to the proposed rule. On the rulemaking process itself, some asked that the comment period be extended to 60 days. In response, HHS says that the 30-day comment period provided adequate opportunity to provide comment. In response to those who asked that HHS monitor and oversee the implementation of the premium stabilization programs, HHS says that it takes seriously its responsibility to do that in order to protect consumers, prevent fraud and abuse, and ensure that the programs achieve their goals. HHS will provide further detail on the oversight of these programs in future rulemaking and guidance.

A. Provisions of the State Notice of Benefit and Payment Parameters (§153.100)

Under §153.100(c), in the case of a state that seeks to modify the parameters for its reinsurance or risk adjustment methodology, the deadline to publish its state notice of benefit and payment parameters is March 1 of the calendar year prior to the applicable benefit year. Given potential difficulties of states meeting this deadline for the initial benefit year of 2014, CMS had proposed to modify §153.100(c), to require that, for benefit year 2014 only, the notice be published by March 1, 2013, or by the 30th day following publication of the final HHS notice of benefit and payment parameters, whichever was later. If a state that chose to operate reinsurance or risk adjustment failed to publish the required notice within that timeframe, it would have to: (1) adhere to the data requirements for health insurance issuers to receive reinsurance payments that were specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year; (2) forgo the collection of additional reinsurance contributions under §153.220(d) and the use of additional funds for reinsurance payments under §153.220(d)(3); (3) forgo the use of more than one applicable reinsurance entity; and (4) adhere to the risk adjustment methodology and data validation standards published in the annual HHS notice of benefit and payment parameters.

Final Rule. Given the timing of this final rule and its effective date (60 days after its publication), HHS is finalizing its proposed policy that, for 2014 only, a state must publish its notice of benefit and payment parameters by the 30th day following publication of the final rule by deeming the March 1 deadline specified in the existing regulation to be extended until the date that is 30 days after publication of the final rule. (Commenters varied in whether they supported such an extension.)

B. Provisions and Parameters for the Permanent Risk Adjustment Program

HHS notes that the risk adjustment program is a permanent program that transfers funds from lower risk, non-grandfathered plans to higher risk, non-grandfathered plans in the individual and small group markets, in and outside of the Exchanges. Based on HHS' communications with

states, as of February 25, 2013, Massachusetts is the only state electing to operate a risk adjustment program for the 2014 benefit year.

Under section III.B.1 of the proposed rule, HHS proposed standards for HHS approval of a state-operated risk adjustment program (regardless of whether a state elected to use the HHS developed methodology or an alternate, federally certified risk adjustment methodology). Under III.B.2 of the proposed rule, HHS proposed a fee to support its operation of the risk adjustment program. In section III.B.3, HHS proposed a methodology for its use when operating a risk adjustment program on behalf of a state. States operating a risk adjustment program could use this methodology, or submit an alternate methodology, in a process described in III.B.4. of the proposed rule. In section III.B.5, HHS proposed and described a data validation process to use when operating a risk adjustment program on behalf of a state.

A discussion of these proposals and how HHS has addressed them follows.

1. Approval of State-Operated Risk Adjustment

a. Risk Adjustment Approval Process (§153.310)

HHS had proposed to add §153.310(a)(4) based on its authority in §1321(a) of the ACA relating to standards for operation of risk adjustment programs and §1343(b) on criteria and methods to be used in carrying out risk adjustment activities. Beginning in 2015, HHS would carry out the risk adjustment functions on behalf of a state if the state was not approved by HHS (i.e., it was found not to meet the standards proposed in §153.310(c)) to operate a risk adjustment program prior to publication of its notice of benefit and payment parameters.

New proposed paragraph (c) set forth a state's responsibilities with regard to risk adjustment program operations. A state operating a risk adjustment program would have to administer it through an entity meeting certain standards to ensure that such entity had the capacity to operate the program throughout the benefit year. Specifically:

1. The entity must be operationally ready to implement the applicable federally certified risk adjustment methodology and process the resulting payments and charges; and has experience relevant to operating the risk adjustment program.
2. The entity complies with all applicable federal provisions in the administration of the applicable federally certified risk adjustment methodology.
3. The state must conduct oversight and monitoring of its risk adjustment program. (In the preamble, HHS had proposed to examine the state's monitoring plan, including the state's requirements for data integrity and maintenance of records, and the state's standards for use of risk adjustment payments.)²

Under proposed §153.310(d), a state would be required to submit to HHS information, in a form and manner specified by HHS, that it and its risk adjustment entity meet the above requirements.

² HHS plans to provide more detail about oversight in future rulemaking.

Final Rule. Commenters generally agreed with the proposed approach to approving state risk adjustment programs beginning in benefit year 2015. HHS is finalizing these provisions as proposed.

b. Risk Adjustment Approval Process for Benefit Year 2014

Given the unique timing issues for approving a state-operated risk adjustment program for benefit year 2014, HHS had proposed a transitional policy. A state would not be required to obtain approval for 2014. Instead, HHS would request that a state planning to operate its own program consult with HHS to determine its capacity to do so. The state would identify the entity selected to operate risk adjustment, and describe its plans for risk adjustment operations. For 2015 and thereafter, states would have to obtain formal approval under the proposed process but ongoing consultations between HHS and states and their selected risk adjustment entities were envisioned. Through these consultations, states and entities would get feedback from HHS on whether they were adequately demonstrating the capacity of the entity to operate all risk adjustment functions. In the case of a state that failed to produce the requested evidence or make the requested changes in the specified timeframe, HHS could determine that the relevant criteria were not met, and could decline to approve that state's risk adjustment program.

Final Rule: HHS had proposed the transitional policy based on the unique circumstances of 2014, and does not anticipate extending it to future years. Although mindful of concerns expressed by some commenters that states may not be fully ready to operate a complex risk adjustment program for benefit year 2014, HHS notes that each aspect of a state's operations (including data collection) must be performed in line with one of the federally certified risk adjustment methodologies published in this final rule. Any state that begins operation of risk adjustment under this transitional process must obtain formal certification for benefit year 2015. HHS believes this process is sufficiently robust to ensure any state operating risk adjustment in 2014 will be prepared to do so.

2. Risk Adjustment User Fees (§153.610(f))

Under the proposed rule, if a state was not approved by HHS to operate or chose to forgo operating its own risk adjustment program, HHS would operate risk adjustment on the state's behalf. HHS indicated its intent to collect a user fee to support the administration of HHS-operated risk adjustment. The fee would apply to issuers of risk adjustment covered plans in states in which HHS was operating the risk adjustment program. HHS referenced federal policy under Circular No. A-25R with respect to collection of these user fees.

The user fees would be determined based on the costs to HHS of administering risk adjustment programs on behalf of states. These include the costs of contracts to develop the model and methodology, as well as for collections, payments, account management, data collection, program integrity and audit functions, operational and fraud analytics, stakeholder training, and operational support. Federal personnel costs would not be included.

HHS would set the user fee rate as a national per capita rate so as to spread the cost of the program across issuers of risk adjustment covered plans based on enrollment. Specifically, the

projected total costs for HHS to administer the risk adjustment programs on behalf of states would be divided by the expected number of enrollees in risk adjustment covered plans in HHS-operated risk adjustment programs.

An applicable issuer would, therefore, pay a user fee equal to the product of its annual plan enrollment multiplied by the annual per capita risk adjustment user fee rate specified in the annual notice of benefit and payment parameters for the applicable benefit year. Total user fees charged to each issuer would be calculated based on the issuer's monthly enrollment, as provided to HHS using the data collection approach for the risk adjustment program (see below). HHS would collect user fees in June of the year after the applicable benefit year and explained the rationale for this timeframe.

The total cost for HHS to operate the risk adjustment program on behalf of states for 2014 was estimated to be less than \$20 million; the per capita risk adjustment user fee would be no more than \$1.00 per enrollee per year.

Final Rule. In response to comments, HHS is adding §153.610(f), finalizing the risk adjustment user fee assessment and collection approach as proposed. HHS clarifies that enrollment data for each month will be captured by the servers used in the distributed data collection approach. HHS is also finalizing a per capita user fee rate in the annual HHS notice of benefit and payment parameters using the proposed methodology. The user fee will be determined by dividing HHS's total contract costs for risk adjustment operations in the applicable benefit year by the expected annual enrollment in risk adjustment covered plans for that benefit year. Based on this methodology, for benefit year 2014, the per capita annual user fee rate is \$0.96, which HHS will apply as a per-enrollee-per-month risk adjusted user fee of \$0.08. Finally, HHS responds to concerns about the cost implications of the user fee by noting that it is solely for the purpose of funding the costs to HHS of operating the federal risk adjustment program and HHS intends to keep the fee as low as possible.

3. Overview of the Risk Adjustment Methodology HHS Will Implement When Operating Risk Adjustment on Behalf of a State

The HHS proposed risk adjustment methodology, finalized with some changes in this rule, is based on the premise that premiums should reflect the differences in plan benefits and plan efficiency, not the health status of the enrolled population.

In the proposed rule, HHS reprised from its Premium Stabilization rule (see §153.20), that a risk adjustment methodology is made up of the following elements:

- The *risk adjustment model* uses an individual's recorded diagnoses, demographic characteristics, and other variables to determine a risk score, which is a relative measure of how costly that individual is anticipated to be.
- The *calculation of plan average actuarial risk* and *the calculation of payments and charges* average all individual risk scores in a risk adjustment covered plan, make certain adjustments, and calculate the funds transferred between plans. In this proposed rule, these are presented together as the *payment transfer formula*.

- The *data collection approach*, which is the distributed model for obtaining the data need for the risk adjustment model and the payment transfer formula.
- The *schedule for the risk adjustment program* describes the timeframe for risk adjustment operations.

States approved to operate risk adjustment may utilize this risk adjustment methodology, or they may submit an alternate methodology.

HHS noted that the risk adjustment methodology addresses three considerations: (1) the newly insured population; (2) plan metal levels and permissible rating variation; and (3) the need for inter-plan transfers that net to zero. The key feature of the HHS risk adjustment methodology is that the risk score alone does not determine whether a plan is assessed charges or receives payments. Transfers depend not only on a plan's average risk score, but also on its plan-specific cost factors relative to the average of these factors within a risk pool within a state.

The HHS risk adjustment methodology:

- Is developed on commercial claims data for a population similar to the expected population to be risk adjusted;
- Uses the hierarchical condition categories (“HCC”) grouping logic used in the Medicare population, with HCCs refined and selected to reflect the expected risk adjustment population;
- Calculates risk scores using a concurrent model (current year diagnoses predict current year costs);
- Establishes 15 risk adjustment models, one for each combination of metal level (platinum, gold, silver, bronze, catastrophic) and age group (adults, children, infants);
- Results in “balanced” payment transfers within a risk pool within a market within a state;
- Adjusts payment transfers for plan metal level, geographic rating area, induced demand, and age rating, so that transfers reflect health risk and not other cost differences; and
- Transfers funds between plans within a market within a state.

Final Rule: HHS is finalizing the methodology that it will use when operating the risk adjustment program as proposed with the following modifications:

- Individuals over 64 have been added in the demographic factors;
- The cost-sharing reduction (CSR) adjustment factors have been updated for zero cost-sharing plan variations to align with the induced demand factors used in the CSR program;
- Technical corrections have been made to the payment transfer formula;
- HHS has clarified that geographic cost factors will be calculated for each risk pool in each market in a state; and
- HHS has clarified how transfers will be calculated at the plan level.

In response to comments about HHS' general approach and whether the risk adjustment methodology will be sufficiently robust, HHS says that it has worked to customize to the ACA context the Medicare Parts C and D methodology and although it anticipates making future

adjustments to the model, it seeks to balance stakeholders' desire for a stable model in the initial years with introducing model improvements as additional data become available. HHS intends to engage stakeholders throughout this process.

a. Risk Adjustment Applied to Plans in the Individual and Small Group Markets (§153.20); §153.360

HHS had proposed definition changes in §153.20 for the following:

“Risk adjustment covered plan” is defined in the current regulation text as health insurance coverage offered in the individual or small group markets, excluding plans offering excepted benefits and certain other plans, including “any other plan determined not to be a risk adjustment covered plan in the annual HHS notice of benefit and payment parameters.” HHS proposed to replace the text in quotes with “and any plan determined not to be a risk adjusted covered plan in the applicable federally certified risk adjustment methodology.” Under this revised definition, HHS would describe any plans not determined to be risk adjustment covered plans under the HHS risk adjustment methodology in the annual notice of benefit and payment parameters, which is subject to notice and comment.

Plans Not Subject to Market Reforms. CMS proposed how to treat plans that are not subject to the market reforms (see the November 26, 2012 “Market Reform and Essential Health Benefits and Actuarial Value” proposed rules) for purposes of risk adjustment and describes related policy decisions.³ (States could propose different approaches to these plans and to risk pooling in state alternate methodologies, subject to the requirements established at §153.330(b) in the proposed rule.) HHS also explained its proposed approach to risk adjustment when states elect to merge the risk pools of their individual and small group markets. Finally, HHS explained its proposed risk adjustment approach in the case of an issuer licensed in one state but with enrollment in another state.

HHS observed that plans not subject to the ACA market reform rules are able to effectively minimize actuarial risk (because, for example, they do not have to accept all applicants on a guaranteed issue basis) and, therefore, should not be subject to risk adjustment charges nor receive risk adjustment payments. In addition, they would not be subject to the issuer requirements in subparts G and H. Those plans issued in 2013 that are subject to the market reform requirements upon renewal, however, would be subject to risk adjustment (and the related requirements) upon renewal.

Student health plans: HHS proposed that these not be subject to risk adjustment and related requirements.

Catastrophic plans: Because of the unique characteristics of this population (e.g., under 30 or individuals for whom insurance is deemed unaffordable), HHS proposed to establish “criteria and methods” to risk adjust catastrophic plans in a separate risk pool from the general (metal level) risk pool. The specific mechanisms for assessing risk, and for calculating payments and charges, were described. These plans would also be

³ See the final market reform rules in the February 27, 2013 *Federal Register* (78 FR 13406).

required to comply with related risk adjustment program requirements under subparts G and H.

Merger of Markets: If a state elected to merge its individual and small group markets and if HHS was operating risk adjustment for that state, HHS would apply risk adjustment to a single merged pool. In such a case, rather than transferring funds between individual market plans only and between small group market plans only, HHS would transfer funds between all individual and small group market plans, considered as one market. In this case, the state average premium would be the average premium of all applicable individual and small group market plans in the applicable risk pool, and normalization would occur across all plans in the applicable risk pool in the individual and small group market.

Risk adjustment in state of licensure: Risk adjustment is a state-based program and requirements may differ from state to state. However, a plan licensed in a state (and therefore subject to that state's rate and benefit requirements) may enroll individuals in multiple states. To help ensure that policies in the small group market were subject to risk adjustment programs linked to the state rate and benefit requirements applicable to that policy, HHS proposed in §153.360 that a risk adjustment covered plan be subject to risk adjustment in the state in which the policy was filed and approved.

Final Rule. HHS is finalizing these provisions as proposed but with a clarification that risk adjustment covered plans in the small group market will be subject to risk adjustment in the state in which the employer's policy is filed and approved. That clarification is in response to comments. HHS also received comments that expressed support for its proposed approach to student health plans, plans not subject to market reform rules, and catastrophic plans. Several urged HHS to align the single risk pool approach to student health plans with the proposed approach in risk adjustment. Some expressed concern that separately risk adjusting catastrophic plans would prevent the enrollees in these plans from contributing to the general risk pool. HHS notes that provisions related to the single risk pool provision were finalized in the Market Reform Rule (see February 27, 2013 *Federal Register*).

b. Overview of the Risk Adjustment Model

As detailed more below, each proposed HHS risk adjustment model predicts plan liability for an enrollee based on that person's age, sex, and diagnoses (risk factors), producing a risk score. HHS had proposed separate models for adults, children, and infants to account for cost differences in each of these age groups. The adult and child models are additive; i.e., the relative costs assigned to an individual's age, sex, and diagnoses are added together to produce a risk score. Infant risk scores are determined by inclusion in one of 25 mutually exclusive groups based on the infant's maturity and the severity of its diagnoses. If applicable, the risk score is multiplied by a cost-sharing reduction adjustment.

The enrollment-weighted average risk score of all enrollees in a particular risk adjustment covered plan within a geographic rating area are then input into the payment transfer formula, as

described in section III.B.3.c. of the proposed rule, to determine an issuer's payment or charge for a particular plan.

Each HHS risk adjustment model predicts individual-level risk scores, but is designed to predict average group costs to account for risk across plans. This method accords with the Actuarial Standard Board's Actuarial Standard of Practice for risk classification.

HHS is finalizing the risk adjustment models with modifications: a typographical error was fixed to include individuals over 64 in the demographic factors; HHS has clarified the calculation of age for infants who were born in one benefit year and discharged in the following benefit year, and the CSR adjustment factors have been adjusted to align with the induced demand factors used in the CSR program.

(1) Data Used to Develop the HHS Risk Adjustment Models

Each HHS risk adjustment model was calibrated using de-identified data⁴ for individuals living in all states, aged 0-64 enrolled in commercial insurance plans. The proposed rule's preamble provided information on the specific data base and its contents as well as decision rules related to classification of enrollees in different types of plans. This information is restated here (although it is not described again in the final rule).

Diagnoses for model calibration were extracted from facility and professional claims (with certain exceptions). The concurrent model sample (approximately 20 million individuals) was generated using the following criteria: (1) the enrollee had to be enrolled in a fee-for-service (FFS) plan; (2) the enrollee must not have incurred any claims paid on a capitated basis; and (3) the enrollee must have been enrolled in a plan with drug benefits and mental health and substance abuse coverage.⁵ The final database reflected HHS's best approximation of the ACA's essential health benefits package, which also includes prescription drug and mental health and substance abuse coverage. Inpatient, outpatient, and prescription drug expenditures for each enrollee were calculated by summing gross covered charges in, respectively, the inpatient, outpatient, and prescription drug services files.⁶ Plan liability expenditures for a given plan type (platinum, gold, silver, bronze, catastrophic) were defined by applying the applicable standardized benefit design to total expenditures. To more accurately reflect expected expenditures for 2014, the 2010 total expenditures were increased for projected cost growth. Average monthly expenditures were defined as the enrollee's expenditures for the enrollment period divided by the number of enrollment months. Annualized expenditures (total or plan liability) were defined as average monthly expenditures multiplied by 12. Data for each individual was weighted by months of enrollment divided by 12.

HHS explained in the proposed rule's preamble that the HHS risk adjustment model is a concurrent model, taking diagnoses from a given period to predict cost in the same period. It proposed using a concurrent model (as opposed to the more typically used prospective model)

⁴ Truven Health Analytics 2010 MarketScan® Commercial Claims and Encounters database (MarketScan)

⁵ HHS explained that it limited the modeling sampling to enrollees in FFS plans because costs on non-FFS claims may not represent the full cost of care associated with a disease.

⁶ "Gross covered charges" equals submitted charges minus non-covered charges minus pricing reductions.

because 2013 diagnostic data would not be available for use in the model in 2014; also it would be better able to handle expected changes by individuals from one plan to another or between programs because individuals newly enrolling in health plans may not have prior data available that can be used for risk adjustment.

HHS also noted that it was not including prescription drug use as a predictor in each HHS risk adjustment model because inclusion of such information (which may be useful for predicting expenditures) could create “adverse incentives to modify discretionary prescribing.”

Final Rule. HHS notes that in response to comments in support or opposition to the inclusion of prescription drug data, it is finalizing the proposal to exclude such data for the initial HHS risk adjustment models but will consider how they could be included in future models. In response to comments in support or opposed to the concurrent approach, HHS reiterates the rationale for retaining it in the final rule but it plans to investigate the feasibility of transitioning to a prospective approach in the future.

In response to comments on HHS’ approach to account for infant claims if there is no separate infant birth claim from which to gather diagnoses, HHS says that if an infant claim cannot be separated, HHS will assign the infant to the lowest severity category and the “term” maturity category. HHS does not intend to unbundle claims in operation.

(2) Principles of Risk Adjustment and the Hierarchical Condition Category (HCC) Classification System

HHS had proposed to use a diagnostic classification system. This determines which diagnosis codes should be included, how the diagnosis codes should be grouped, and how the diagnostic groupings should interact for risk adjustment purposes. The ten principles that had been used to develop the hierarchical condition category (HCC) classification system for the Medicare risk adjustment model guided the creation of the proposed HHS risk adjustment model and these were described in the preamble of the proposed rule.

HHS explained in the proposed rule that the risk adjustment model for the individual and small group markets is referred to as HHS HCCs. The CMS HCC diagnostic classification (which is used for Medicare Part C plans) provided the diagnostic framework for the classification and selection of HCCs for the HHS risk adjustment model. The CMS HCC classification system was reviewed and adapted to account for the different population to create the HHS HCC classification. Three major characteristics of that classification system required modification for use with the HHS risk adjustment model: (1) population; (2) type of spending; and (3) prediction year. The CMS HCCs were developed using data from the aged and/or disabled Medicare population. Although every ICD-9-CM diagnosis code is mapped and categorized into a diagnostic grouping, for some conditions (such as pregnancy) the sample size in the Medicare population is quite low. With larger sample sizes in the commercial population, HCCs were re-examined for infant, child, and adult subpopulations. Additionally, the CMS HCCs are configured to predict medical spending, while HHS HCCs predict both medical and drug spending. Finally, the CMS HCC classification is primarily designed for use with a prospective risk adjustment model. Each HHS risk adjustment model is concurrent, using current year

diagnoses and demographics to predict the current year's spending. Medical conditions may predict current year costs that differ from future costs; HCC and DXG groupings should reflect those differences. HHS explained that in designing the diagnostic classification for the HHS risk adjustment model, certain principles (7, 8 and 9) were prioritized.

HHS selected 127 of the full classification of 264 HHS HCCs for inclusion in the HHS risk adjustment model, choosing those HCCs that were more appropriate for a concurrent model or for the expected risk adjustment population (e.g., low birth weight babies were included). The following criteria were used to determine which HCCs should be included:

- Whether the HCC represents clinically significant medical conditions with significant costs for the target population;
- Whether a sufficient sample size exists to ensure stable results for the HCC;
- Whether excluding the HCC would exclude (or limit the impact of) diagnoses particularly subject to discretionary coding;
- Whether the HCC identifies chronic or systematic conditions that represent insurance risk selection or risk segmentation, rather than random acute events;
- Do not represent poor quality of care; and
- Whether the HCC is applicable to the model age group.

Consistent with the ten risk adjustment principles, each HHS risk adjustment model excludes HHS HCCs containing diagnoses that are vague or nonspecific (for example, symptoms), discretionary in medical treatment or coding (for example, osteoarthritis), or not medically significant (for example, muscle strain). Also excluded are HHS HCCs that do not add to costs.

To balance the competing goals of improving predictive power and limiting coding variability to create a relatively simple risk adjustment model, a number of HHS HCCs were grouped into sets equivalent to a single HCC. CMS explained the rationale for such groupings (e.g., to reduce model complexity or limit up-coding by severity within an HCC hierarchy). After grouping, the number of HHS HCCs included in the proposed HHS risk adjustment model was effectively reduced from 127 to 100.

Final Rule. HHS is finalizing the HHS HCC classification system as proposed as well as the HHS HCCs that are included in the HHS risk adjustment models. Several comments supported the classification system. Some wanted HHS to provide the ICD-9 codes included in each HHS HCC. This information is at:

https://cciio.cms.gov/resources/files/ra_instructions_proposed_1_2013.pdf and

http://cciio.cms.gov/resources/files/ra_tables_proposed_1_2013.xlsx.

HHS intends to provide a final version of these documents to reflect the HHS risk adjustment models in the future. In response to requests for the classification of ICD-10s to HHS HCCs, HHS reports that it is completing the mapping process and will release this information in future guidance. In response to those who asked for additional HHS-HCCs to be included in the models, HHS says that it has finalized the proposal and no new ones have been added.

(3) Factors Included in the Risk Adjustment Models

In the proposed rule's preamble, HHS explained that, in addition to the HHS HCCs included in the HHS risk adjustment model, enrollee risk scores would be calculated from demographic factors. There are 18 age/sex categories for adults, and 8 age/sex categories for children. (Age/sex categories for infants are not used.) Adults are defined as ages 21+, children are ages 2-20, and infants are ages 0-1. The age categories for adult male and female are ages 21-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, and 60+. The age categories for children male and female are ages 2-4, 5-9, 10-14, and 15-20. Age would be defined as age as of the enrollee's last day of enrollment in risk adjustment covered plans within an issuer in the applicable benefit year.

For individuals without any of the HHS HCCs included in the proposed HHS risk adjustment model, predicted expenditures would be based solely on their demographic risk factors. In the calibration data set, 19% of adults, 9% percent of children, and 45% of infants had HCCs included in the risk adjustment models.

Because of the "inherent clinical and cost differences in the adult (age 21+), child (age 2-20), and infant (age 0-1) populations," HHS developed separate risk adjustment models for each age group. The models for adults and children generally have similar specifications, including demographic age/sex categories and HHS HCCs, but differ slightly due to clinical and cost differences. However, infants have certain costs related to hospitalization at birth and can have severe and expensive conditions that do not apply to adults or children, while having relatively low frequencies for most HHS HCCs included in the model compared to adults and children. Therefore, HHS proposed a separate infant model and described its specifications, which involve assigning infants a maturity category (by gestation and birth weight) and a severity category.

Final Rule. HHS notes comments that it received suggesting that the weights of specific factors in the HHS risk adjustment models were lower than expected. Some commenters asked that age be calculated at the time of enrollment rather than as of the enrollee's last day of enrollment some wanted the age for newborns to be defined as the date of birth rather than the age as of the last day of enrollment in a plan. Still others supported the inclusion of a demographic factor to account for individuals age 65 or older or asked that the models include additional factors such as income, receipt of care from an essential community provider, and enrollee language.

In response, HHS says that its models were calibrated using age as of the last month of enrollment due to data limitations. To align with model calibration, an enrollee's age for risk score calculation will be the age as of the enrollee's last day of enrollment in a risk adjustment covered plan in the applicable benefit year (for enrollees in program operation). HHS is clarifying its approach to calculating the age of infants who are born in a benefit year but are not discharged until the following year. In such a case, the infant will be defined as age 0 for both benefit years. For example, if an infant is born in December of 2014 but has a discharge date of January 2015, the infant would be assigned age 0 for purposes of risk score calculation in benefit year 2014 and for the entire 2015 benefit year. With respect to older enrollees, HHS is making a typographical correction to re-label the highest adult age factor as 60+. Because data for individuals 65 or older is not captured in the calibration dataset, the estimation of a separate demographic factor for those 65 or older is impractical at this time. HHS says that are factors

such as income are also not feasible to include due to data limitations. (Tables 2, 4, and 5 contain the final factors for the HHS risk adjustment models at 78 FR 15422-15428.)

(4) Adjustments to Model discussed in the Risk Adjustment White Paper

In the Risk Adjustment White Paper, HHS had discussed the possibility of including adjustments to the HHS risk adjustment model to account for cost-sharing reductions and reinsurance payments and sought comment. In the proposed Notice of Benefit and Payment Parameters, HHS had proposed to include an adjustment for the receipt of cost-sharing reductions in the model, but not to adjust for receipt of reinsurance payments in the model. HHS’ rationale was that under the ACA, enrollees in individual market plans in Exchanges are eligible for cost sharing reductions based on their income and/or Indian status. Such individuals may utilize health care services at a higher rate than would be the case in the absence of cost-sharing reductions. This higher utilization (to the extent not covered by required cost sharing by the enrollees or cost-sharing reductions reimbursed by the federal government) would neither be paid by cost sharing reductions nor built into premiums. The cost sharing reduction adjustment to the HHS risk adjustment models would be based on the adjustment for induced demand for advanced payment of cost-sharing reductions. Regarding reinsurance, HHS said that adjusting for the ACA’s reinsurance payments in the HHS risk adjustment model would address concerns that reinsurance and risk adjustment could compensate twice for the same high-risk individuals. It rejected such an adjustment, however, because: (1) removing reinsurance payments would reduce protections for issuers of reinsurance-eligible plans that enroll high-cost individuals: (2) it would be difficult to determine what portion of reinsurance payments were made for conditions included in each HHS risk adjustment model, and the appropriate model adjustment for these payments; and (3) the size of the reinsurance pool declines over its three-year duration and this would require the methodology to account for reinsurance payments to be modified each year for the HHS risk adjustment model.

Final Rule. HHS finalizes the CSR adjustment factor as proposed but revises it to correct a typographical error and align with the CSR adjustment later in the rule for enrollees in zero cost-sharing plan variations. (See table 1 as reproduced below). HHS also finalizes its proposal not to adjust the HHS risk adjustment models for payments from the temporary reinsurance program.

| Cost Sharing Reduction Adjustment | | |
|--|----------------------------------|-----------------------------------|
| Household Income | Plan Actuarial Value (AV) | Induced Utilization Factor |
| <i>Silver Plan Variant Recipients</i> | | |
| 100-150% of FPL | Plan variation 94% | 1.12 |
| 150-200% of FPL | Plan variation 87% | 1.12 |
| 200-250% of FPL | Plan variation 73% | 1.00 |
| >250% of FPL | Plan variation 70% | 1.00 |
| <i>Zero Cost-Sharing Recipients</i> | | |
| <300% of FPL | Platinum (90%) | 1.00 |
| <300% of FPL | Gold (80%) | 1.07 |
| <300% of FPL | Silver (70%) | 1.12 |
| <300% of FPL | Bronze (60%) | 1.15 |
| >300% of FPL | Limited Cost-Sharing Recipients | 1.00 |
| Table 1. 78 FR 15421 | | |

(5) Model Performance Statistics

The standard way to evaluate whether a risk adjustment model performs well is to assess its predictive accuracy. The statistic (R-Squared or R^2) calculates the percentage of individual variation explained by a model overall. Predictive ratios are used to measure the predictive accuracy of a model for different validation groups or subpopulations. The ratio represents how well the model does on average at predicting plan liability for that subpopulation. A subpopulation that is predicted perfectly would have a predictive ratio of 1.0.

In the proposed rule's preamble, HHS stated that for each of its risk adjustment models, the R^2 and the predictive ratio are in the range of published estimates for concurrent risk adjustment models.

Final Rule. The R^2 s for the HHS risk adjustment models are displayed in Table 8 of the final rule (78 *FR* 15430). They range from a low of .288 for the bronze adult model and a high of .36 for the platinum adult model. HHS also says that the predictive ratios for the overall samples for each of the 15 models are within the range of estimates for other health risk adjustment models.

(6) Summary of Models

In the final rule, HHS provides a summary of the final HHS risk adjustment models and references data tables where the demographic and diagnosis factors are displayed (see 78 *FR* 15422 et seq.).

c. Overview of the Payment Transfer Formula

In the preamble to the proposed rule, HHS provided a high level explanation of its approach to making payments to issuers with above average actuarial risk and collecting payments from plans with below average actuarial risk as measured by the HHS risk adjustment models. Payments and charges were referred to as "transfers." HHS defined the calculation of plan average actuarial risk and the calculation of payments and charges in the Premium Stabilization Rule. These concepts were combined in a risk adjustment payment transfer formula.

HHS proposed to calculate risk adjustment transfers after the close of the applicable benefit year, following the completion of issuer risk adjustment data reporting. Under §153.310(e), as proposed to be renumbered, HHS would invoice issuers of risk adjustment covered plans for transfers by June 30 of the year following the applicable benefit year.

The proposed payment transfer formula included a set of cost adjustment terms that would require transfers to be calculated at the geographic rating area level for each plan (thus, two separate transfer amounts would be calculated for a plan that operates in two rating areas). Payment transfer amounts would be aggregated at the issuer level (i.e., at the level of the entity licensed by the state) such that each issuer would receive an invoice and a report detailing the basis for the net payment that would be made or the charge that would be owed. The invoice

would also include plan-level risk adjustment information that could be used in the issuer's risk corridors calculations.

The proposed payment transfer formula was designed to provide a per member per month (PMPM) transfer amount. The PMPM transfer amount derived from the payment transfer formula would be multiplied by each plan's total member months for the benefit year to determine the total payment due or charge owed by the issuer for that plan in a rating area.

Conceptual Overview of the Payment Transfer Formula

In the preamble to the proposed rule, HHS provided a narrative explanation and the mathematical formulae for its proposed payment transfer calculations. (Some but not all of the detail is repeated in the final rule's preamble.) Conceptually, the goal of payment transfers is to provide plans with payments to help cover their actual risk exposure beyond the premiums the plans would charge reflecting allowable rating and their applicable cost factors. In other words, payments would help cover excess actuarial risk due to risk selection.

HHS proposed that the payment transfer formula for 2014 be based on the difference between two plan premium estimates: (1) a premium based on plan-specific risk selection; and (2) a premium without risk selection. Transfers are intended to bridge the gap between these two premium estimates.

Both of these premium estimates would be based on the state average premium, defined as the average premium requirement for providing insurance to the applicable market population.

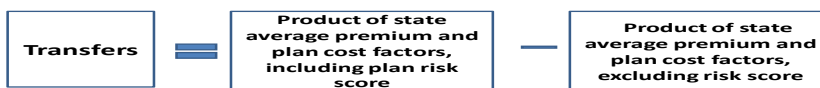
The proposed payment transfer formula develops plan premium estimates by adjusting the state average premium to account for plan specific characteristics such as benefit differences. This approach also assumes that all plans have premiums that can be decomposed into the state average premium and a set of adjustment factors (identified below but for example, include a plan's actuarial value or "AV") and that all plans would have the same premium if the adjustment factors were held constant across plans.

The derivation of the payment transfers also assumes that plans "price to cost," that is, that competition among plans for enrollees drives plans' premiums to their premium requirements. Therefore, "premiums" are considered to be "costs" or "premium requirements."

The state average premium was then multiplied by the adjustment factors to develop the plan premium estimates used in the payment transfer formula. The factors are relative measures that compare how plans differ from the market average with respect to the cost factors. This means that the product of the adjustments is normalized to the market average product of the cost factors.

The figure below shows how the state average premium, the plan average risk score, and other plan-specific cost factors are used in the proposed payment transfer formula to develop the two plan premium estimates that are used to calculate payment transfers:

Calculating Payment Transfers



In the subsequent technical description in the proposed rule’s preamble, HHS explained the formulae (and the component variables) for estimating plan premiums with and without risk selection and calculating the amount of transfers. Again, transfers would be calculated as the difference between the plan premium estimate reflecting risk selection and the plan premium estimate not reflecting risk selection. The difference between the two premium estimates in the payment transfer formula would determine whether a plan would pay a risk transfer charge or receive a risk transfer payment. The value of the plan average risk score by itself would not determine whether a plan would be assessed a charge or receive a payment. Even if the risk score was greater than 1.0, it is possible that the plan would be assessed a charge if the premium compensation that the plan might receive through its rating practices (as measured through the allowable rating factor) exceeded the plan’s predicted liability associated with risk selection.

HHS also noted that plans with higher AV would, other things being equal, also have higher risk scores. This is because the metal level-specific risk adjustment models that are used to predict plan liability assume different cost sharing and levels of plan liability.

HHS noted further that transfers would be calculated at the risk pool level. Each state would have a risk pool for all of its metal-level plans. Catastrophic plans would be treated as a separate risk pool for purposes of risk adjustment. Individual and small group market plans would either be pooled together or treated as separate risk pools, depending on the state.

Normalization and Budget Neutral Transfers. Each of the two premium terms in the payment transfer formula would be divided by its average, (normalized to 1.0). Thus, the average of the difference between these terms would be zero. This ensures that transfers across a risk pool would net to zero.

Calculation of Transfer Formula Inputs. HHS next explained in greater detail each component of the proposed payment transfer formula, how it was computed (including the mathematical formulae) and how the component affects transfers. The components include:

- Plan average risk score – an adjustment is included to account for the family rating rules proposed in the Market Reform Rule.
- Billable members – with the exception of the plan average risk score, all other calculations are based on billable members (i.e., children are not counted toward the family premium are excluded).
- State average premium.

- Actuarial value – each metal level has an AV (e.g., bronze = .60) and that AV would be included in the transfer model. Note that HHS assigns an AV of .57 to catastrophic plans.
- Allowable rating variation – only the age factor (3:1) would be accounted for in the payment transfer model. The other allowable rating factors of tobacco use and wellness discounts are not included because they are discretionary and CMS wants to maintain issuer flexibility with respect to their use in rating. Family size differences are counted for in the “billable members” variable.
- Induced demand – an adjustment is needed so that plans are not paid for the effect of induced demand on enrollee spending attributable to the different metal levels.
- Geographic area cost variation – this adjustment is needed to account for some plan costs, such as input prices or utilization rates, which vary geographically and are likely to affect plan premiums. By including the adjustment, these costs would be reflected in premiums, rather than being offset by transfers. A geographic cost factor (GCF) would be calculated for each rating area, based on the observed average silver plan premiums in a geographic area relative to the statewide average silver plan premium. Using the formulae described by HHS, the enrollment-weighted statewide average of plan geographic cost factor values would equal 1.0. Thus, a GCF equal to 1.15 indicates that the plan operates in a geographic area where costs are, on average, 15% higher than the statewide average.

Calculation of Plan Transfer Payments. The PMPM transfer payment calculated from the proposed payment transfer formula would be multiplied by the total number of plan member months for billable members to calculate the total plan level payment. As noted above, transfers would be calculated at the plan level within rating areas (that is, a plan operating in two rating areas would be treated as two separate plans for the purposes of calculating transfers).

Final Rule. HHS has finalized the payment transfer formula as proposed, with some “minor” technical modifications to certain of the adjustment factors.

- *State Average Premium.* HHS has made a technical correction to the formula to calculate PMPM premiums. The change has been made in the denominator (see 78 FR 15431-2). Otherwise it is finalizing its proposal to base the payment transfer formula on the State average premium.
- *Actuarial Value (AV).* HHS is finalizing its proposed adjustment in the payment transfer formula for a plan’s actuarial value without modification. The table below shows the AV adjustment that will be used for each category of metal level plans.

| Actuarial Value Adjustment Used for Each Metal Level in the Payment Transfer Formula | |
|---|----------------------|
| Metal Level | AV Adjustment |
| Catastrophic | 0.57 |
| Bronze | 0.60 |
| Silver | 0.70 |
| Gold | 0.80 |
| Platinum | 0.90 |
| 78 FR 15433, Table 9. | |

- *Induced Demand.* HHS is finalizing this provision as proposed with a correction in a typographical error. The table below shows the induced demand adjustment that will be used for each metal level in the payment transfer formula.

| Induced Demand Adjustment Used for Each Metal Level in the Payment Transfer Formula | |
|--|----------------------|
| Metal Level | AV Adjustment |
| Catastrophic | 1.00 |
| Bronze | 1.00 |
| Silver | 1.03 |
| Gold | 1.08 |
| Platinum | 1.15 |
| 78 FR 15433, Table 11. | |

- *Geographic Area Cost Variation.* HHS is adopting the provision as proposed noting though that the modification regarding the calculation of the plan average premium also applies in the formula.

d. Overview of the Data Collection Approach

HHS had proposed a technical correction to the definition of risk adjustment data collection approach in §153.30. “Audited” would be deleted so that the data collection approach means “the specific procedures by which risk adjustment data is to be stored, collected, accessed, transmitted, validated and the applicable timeframes, data formats and privacy and security standards.” Thus auditing is not part of the data collection approach but is part of the data validation process.

HHS also proposed to modify §153.340(b)(3) by adding the additional restriction that “Use and disclosure of personally identifiable information is limited to those purposes for which the personally identifiable information was collected (including for purposes of data validation).” This would further ensure the privacy and security of potentially sensitive data by limiting the use or disclosure of any personally identifiable information collected as a part of this program.

The distributed data collection approach HHS proposed to use when operating risk adjustment on behalf of the state is described below.

Final Rule. HHS received no comments on these proposals and is adopting them as final without modification.

e. Schedule for Risk Adjustment (§153.730)

Under existing §153.610(a), issuers of risk adjustment covered plans are required to provide HHS with risk adjustment data in the form and manner specified by HHS. Under the HHS operated risk adjustment program, issuers will not send, but must make available to HHS,

anonymized claims and enrollment data for benefit year 2014 beginning January 1, 2014. Enrollee risk scores will be calculated based on enrollment periods and claims dates of service that occur between January 1, 2014 and December 31, 2014. Enrollee risk scores for subsequent benefit years will be calculated based on claims and enrollment periods for that same benefit year. Under proposed §153.730, claims to be used in the risk score calculation would have to be made available to HHS by April 30 of the year following the benefit year. HHS said in the proposed rule that this date provides for ample claims runout to ensure that diagnoses for the benefit year are captured, while providing HHS sufficient time to run enrollee risk score, plan average risk, and payments and charges calculations and meet the June 30 deadline described at the redesignated §153.310(e).

Final Rule. HHS received some comments that it should provide issuers with interim reports of risk scores and other information. In response, HHS says that it is committed to implementing the risk adjustment program in a transparent way, and to provide issuers with the information necessary for program operations and rate development. HHS is assessing the feasibility of providing program information prior to the close of the benefit year.

4. State Alternate Methodology

a. Technical Correction

CMS proposed a technical correction to the regulatory language at §153.320(a)(1) and (a)(2) to make clear that federally certified risk adjustment methodologies must be certified for use each year. This change has been incorporated in the final rule.

b. State Alternate Risk Adjustment Methodology Evaluation Criteria (§153.330(b))

Overview. HHS has finalized its proposed rules related to the state alternate risk adjustment methodology without modifications. It identifies some issues for which it will provide future guidance.

HHS proposed modifications to its criteria for a state alternate risk adjustment methodology that were specified in the Premium Stabilization Rule. Additional criteria were proposed for §153.330 to certify such methodologies. HHS noted that requests for state alternate methodologies would be accepted up to 30 days after publication of this proposed rule. HHS would review a state's request only if it had submitted an Exchange Blueprint application and indicated on that application its intent to operate a risk adjustment program (or, in later years, if it is operating or has been approved to operate an Exchange). HHS said that it would work with states as they develop their alternate methodologies.

Under the proposed revised criteria, HHS would evaluate the extent to which an alternate risk adjustment methodology:

- Explains the variation in health care costs of a given population;
- Links risk factors to daily clinical practices and is clinically meaningful to providers;

- Encourages favorable behavior among providers and health plans and discourages unfavorable behavior;
- Uses data that are complete, high in quality, and available in a timely fashion;
- Is easy for stakeholders to understand and implement;
- Provides stable risk scores over time and across plans; and
- Minimizes administrative costs.

HHS gave the example that to determine the extent to which an alternate methodology meets the first criterion of explaining the variation in health care costs of a given population, it would consider whether the model was calibrated from data reflecting the applicable market benefits, was calibrated on a sample that is reasonably representative of the anticipated risk adjustment population, and was calibrated using a sufficient sample to ensure stable weights across time and plans. In addition, HHS would consider whether the methodology has suitably categorized the types of plans subject or not subject to risk adjustment, given the overall approach taken by the methodology and the goal of the program to account for plan average actuarial risk. States would have to provide a rationale for the methodology's approach to the plans subject to risk adjustment.

A state alternate methodology would further be evaluated for the following:

- It must not discriminate against individuals because of age, disability, or expected length of life, and should take into account the health care needs of diverse segments of the risk adjustment population, including women, children, persons with disabilities, and other vulnerable groups.
- It must comply with the federal requirements to have a schedule that provides annual notification to issuers of risk adjustment covered plans of payments and charges by June 30 of the year following the benefit year.
- It must meet minimum requirements for data collection under risk adjustment, including standards relating to data privacy and security. HHS noted that while the federal approach would not directly collect data from insurers, but instead would use a distributed approach that would not include personally identifiable information, the Premium Stabilization Rule gives states the flexibility to design their own data collection approach, provided privacy and security standards are met. HHS considers the privacy and security of enrollees' data to be of paramount importance and the state's data collection approach must protect personally identifiable information, if any, that is stored, transmitted, or analyzed, to be certified. The application for certification of the alternate methodology should identify which data elements contain personally identifiable information, and should specify how the state would meet these data and privacy security requirements.
- It accounts for payment transfers across metal levels so as to mitigate adverse selection across as well as within metal levels.
- The elements of the methodology should align with each other. For example, does the data collection approach result in the collection of data required by the risk adjustment model to calculate individual risk scores?

HHS proposed to give states flexibility with respect to whether their alternate methodology applies risk adjustment to catastrophic plans in their own risk pool and/or includes plans not subject to the federal market reform rules in the state risk adjustment program.

Alternate methodologies submitted by states that were approved as federally certified risk adjustment methodologies for 2014 would be published in the final 2014 HHS notice of benefit and payment parameters.

Final Rule. HHS has adopted these proposals as final without change. In response to a comment requesting further clarity on the requirement that a state's request to operate an alternate methodology must include an assessment of the extent to which the methodology encourages favorable behavior among providers and discourages unfavorable behavior, HHS says that in addition to the example provided in the proposed rule's preamble, it will provide further guidance on these criteria in connection with its evaluation of particular proposed state alternate methodologies.

In response to a comment recommending that state alternate methodology applications be made available to the public, HHS says that it will publish these in the annual HHS notice of benefit and payment parameters, which it believes meets its commitment to transparency.

c. Payment and Charges

In the proposed rule's preamble, HHS referenced the payment transfer formula proposed in this rule and reiterated that this formula utilizes the plan average risk score and the state average premium and is based on a plan liability model. States could adapt this formula to a total expenditure model by replacing the plan liability risk score in the formula with the total expenditure risk score of a plan, and multiplying the total expenditure risk score by an adjustment for AV. States would have the flexibility to select the adjustments used for the calculation of payments and charges in their alternate methodologies. While the proposed HHS payment transfer formula would make adjustments for AV, age rating factor, geographic cost differences, and induced demand, states would have the option of including or excluding any of these adjustments. States could also include other adjustments in the calculation of payments and charges under their alternate methodologies. Adjustments could be added to or removed from the basic payment transfer formula as long as these factors were normalized, so that transfers netted to zero.

Final rule. HHS has adopted this proposed provision as final without changes. No comments were received on this provision.

5. Risk Adjustment Data Validation

Overview. HHS has adopted its proposed risk adjustment data provisions as final without modification. It provides some clarifications and indicates future guidance is forthcoming in response to some comments.

In the proposed rule's preamble, HHS explained that existing §153.350 specified standards applicable to states, or HHS on behalf of states, in validating risk adjustment data. States operating their own program and HHS are required to establish a process to appeal findings from data validation and allow the state, or HHS on behalf of the state, to adjust risk adjustment payments and charges based on data validation findings. HHS said that these requirements are important to ensure credibility of risk adjustment data and establish issuer confidence in the risk adjustment program. Moreover, as error rates derived from the results of data validation may be used to make adjustments to the plan average actuarial risk calculated for a risk adjustment covered plan, the data validation process will ensure that such transfers accurately reflect each plan's average enrollee risk.

In the proposed rule, HHS built upon guidance released in the Risk Adjustment Bulletin and in discussions held with stakeholders at the Risk Adjustment Spring Meeting to define data validation standards applicable to issuers of risk adjustment covered plans when HHS operates risk adjustment on behalf of a state.

HHS proposed that, beginning in 2014, HHS conduct a six-stage data validation program when operating risk adjustment on behalf of a state: (1) sample selection; (2) initial validation audit; (3) second validation audit; (4) error estimation; (5) appeals; and (6) payment adjustments. However, states would not be required to adopt this HHS data validation methodology.

Final Rule. In response to a comment asking that the cost of the audits associated with data validation be paid by the federal government, HHS responds that its policy is that costs related to the second validation audit process be borne by the federal government, while costs associated with initial validation audit process will be borne by the applicable issuer. A state may choose to allocate the costs of data validation differently when operating its own risk adjustment program. In response to a request for clarification on how issuers that leave a market during the year will affect the statewide data validation process, HHS advises that further detail on this and other validation issues will be provided in future rulemaking and guidance.

a. Data Validation Standards When HHS Operates Risk Adjustment (§153.630)

Proposed new §153.630 would set forth risk adjustment data validation standards applicable to all issuers of risk adjustment covered plans when HHS is operating risk adjustment for a state. In general, issuers of risk adjustment covered plans have an initial and second validation audit of risk adjustment data (these are the second and third stages of the six-stage data validation program described below).

(1) Sample Selection (§153.630)

In the proposed rule's preamble, HHS reiterated the requirement under the Premium Stabilization Rule for HHS to validate a statistically valid sample from each issuer that submits data for risk adjustment every year. Such sample selection is the first stage of HHS' six-stage risk adjustment data validation process. The sample would be selected for each issuer in accordance with standards described in this section and would have to be adequate such that the estimated payment errors would be statistically sound and so that enrollee-level risk score

distributions reflect enrollee characteristics for each issuer. HHS would seek to balance the need to ensure statistical soundness of the sample and minimizing operational burden on issuers, providers and HHS.

HHS expected that each issuer's initial validation audit sample within a state would consist of approximately 300 enrollees, with up to two-thirds of the sample consisting of enrollees with HCCs. Its assumptions about sample size and the population distributions might be updated as the Department gained experience.

Final Rule. HHS has finalized this provision as proposed. In response to requests for additional information, HHS says that it will provide more detailed information on the HHS sampling methodology in future rulemaking and guidance, including sample sizes and expected tolerances and confidence intervals.

(2) Initial Validation Audit (§153.630(b))

HHS had proposed that once it selected the audit samples, issuers would be required to conduct independent audits of the risk adjustment data for their initial validation audit sample enrollees. Issuers would be required to engage one or more auditors to conduct these independent initial validation audits. Auditors would have to be reasonably capable of performing the audit and free from conflicts of interest. The audit would have to be completed and the information regarding the initial validation audit sent to HHS in the manner and timeframe specified by HHS.

HHS noted that for enrollees included in the HHS-specified audit sample, issuers of risk adjustment covered plans would be required to provide enrollment and medical record documentation to the initial validation auditor to validate the demographic and health status data of each enrollee. Issuers would be given considerable autonomy in selecting their initial validation auditors so long as they conduct data validation audits in accordance with HHS' audit standards. HHS identified three methods for establishing these standards: (1) HHS or an HHS-designated entity could prospectively certify auditors for these audits; (2) HHS could develop standards that issuers and initial validation auditors would follow, without any requirement of prior HHS certification or approval of auditors; or HHS could issue non-binding, "best practice" guidelines for issuers and auditors.

Final Rule. HHS is finalizing these provisions as proposed. HHS notes in response to a comment that it will clarify in future rulemaking and guidance the uniform audit that that issuers and auditors will be subject to. In response to comments supporting a certification requirement for auditor firms prior to acting as a validation auditor, HHS says that it believes that issuers will be diligent in selecting audit entities capable of complying with HHS audit standards, and that adequate enforcement remedies exist should an audit entity fail to comply with the standards. HHS will monitor the performance of validation auditors to determine whether such certification or additional safeguards are necessary in the future.

(3) Second Validation Audit (§153.630(c))

HHS had proposed to select a subsample of the risk adjustment data validated by the initial validation audit for a second validation audit. All standards for such audits would have to be met and the issuer would have to cooperate with and ensure that the initial auditor cooperated with HHS and the second validation auditor. Issuers would be required to submit the data for the audit to HHS or its auditor in an electronic format to be determined by HHS. The second validation auditor would inform the issuers of error findings based on its review.

Final Rule. HHS is finalizing these provisions as proposed.

(4) Error Estimation

HHS had proposed to estimate risk score error rates based on the findings from the data validation process. It would conduct analyses to determine the most effective methodology for adjusting plan risk scores for calculating risk adjustment payment transfers. Upon completion of the second validation audit and error estimation stages of HHS's data validation process, HHS would provide each issuer with enrollee-level audit results and error estimates at the issuer level.

Final Rule. HHS is finalizing these provisions as proposed. Following additional engagement with stakeholders, HHS expects to provide further detail on its approach to error estimation and payment transfer adjustments in future rulemaking and guidance. HHS also advises that it intends to apply error adjustments if an issuer under-reports its risk scores; more detail on these adjustments is forthcoming.

(5) Appeals (§153.630(d))

Under proposed §153.603(d), issuers could appeal the findings of a second validation audit or the application of a risk score error rate to its risk adjustment payments and charges. HHS advised in the proposed rule's preamble that appeals would likely be limited to instances in which the audit was not conducted in accordance with second validation audit standards established by HHS. Further detail on this process would be provided in future guidance or regulation.

Final Rule. HHS is finalizing these provisions as proposed.

(6) Payment Adjustments (§153.630(e))

HHS had proposed that it would use a prospective approach when making such payment adjustments and explained why this approach should be pursued. It would use an issuer's data validation error estimates from the prior year to adjust the issuer's average risk score in current year for transfers. HHS could adjust payments and charges for issuers that did not comply with the initial or second audit standards.

Final Rule. HHS adopts this provision as final. After consultations with stakeholders and prior to further rulemaking on data validation, HHS will address the question of how this prospective

approach will impact plan pricing assumptions and how actuarial soundness will be maintained if an issuer's risk profile changes substantially from year to year.

b. Proposed HHS-Operated Data Validation Process for Benefit Years 2014 and 2015

HHS had proposed that issuers of risk adjustment covered plans adhere to the proposed data validation process for the 2014 benefit year. Given the complexity of the risk adjustment program and the data validation process as well as the uncertainty in the market that will exist in 2014, HHS was concerned that “adjusting payments and charges without first gathering information on the prevalence of error could lead to a costly and potentially ineffective audit program.” HHS thus proposed that while it would require issuers to conduct the initial validation audit and for the Department to conduct a second validation audit for benefit years 2014 and 2015, no adjustment would be made to payments and charges based on validation results on data from the 2014 and 2015 benefit years. HHS said that the data validation conducted during the first two years of the program would serve an important educational purpose for issuers and providers. Also, other remedies, such as prosecution under the False Claims Act, might be applicable to issuers not in compliance with the risk adjustment program requirements.

HHS also noted that it was considering publishing a report on the error rates discovered during 2014 and 2015 to inform its audit program. For this report, it might conduct special studies of the second validation audits aimed at comparing the error rate results of the initial validation auditors and second validation audits, looking at discrepancies that may result between the two audits. HHS elaborated on the error rate analysis. HHS anticipated that a small number of audit firms would perform the majority of initial audits.

Final Rule. HHS is going forward with its plan not to adjust payments based on error rates for 2014 and 2015, a plan supported by some but not all commenters. HHS will publish a report on error rates in the first two years. The intent is to provide issuers and auditors information on the level of error in the commercial market under the HHS-operated risk adjustment program. Additionally, HHS may study the extent to which errors at the auditor level contribute to risk score error rate findings during the initial validation audits. HHS does not anticipate that the report will identify providers, but it may identify issuers. It does anticipate that the report will identify the error rates attributable to auditors. In response to a request for further clarification on the timeframe in which issuers will be directed to provide sample data for a benefit year and on program integrity efforts if payment transfers are not altered by data validation audit results, HHS says that it will issue further guidance and rulemaking on these matters.

c. Data Security and Transmission §153.630(f)

Under proposed §153.630(f), issuers would have to submit any risk adjustment data and source documentation specified by HHS for the initial and second validation audits to HHS in the manner and timeframe established by HHS. An issuer also would have to ensure that it and its initial validation auditor comply with the security standards described in §164.308, §164.310, and §164.312.

Final Rule. HHS is finalizing these provisions as proposed.

6. State-Submitted Alternative Risk Adjustment Methodology

HHS received an alternate risk adjustment methodology from one state, the Commonwealth of Massachusetts. HHS is certifying this methodology as a federally certified methodology for use in that state. A summary of that methodology, as prepared by the Commonwealth, is included in the preamble of the final rule (see 78 *FR* 15439-15452).

C. Provisions and Parameters for the Transitional Reinsurance Program

The ACA directs that a transitional reinsurance program be established in each state to help stabilize premiums for coverage in the individual market from 2014 through 2016. The intent is for reinsurance to alleviate the need by issuers to build into their health insurance premiums the risk of enrolling individuals with significant unmet medical needs.

In its proposed rule, HHS proposed a number of modifications to the reinsurance program requirements that were set forth in the Premium Stabilization Rule. These modifications were intended to “provide reinsurance payments in an efficient, fair, and accurate manner, where they are needed most, to effectively stabilize premiums nationally . . . and to implement the reinsurance program in a manner that minimizes the administrative burden of collecting contributions and making reinsurance payments.” In addition, for the HHS-operated reinsurance program, reinsurance payments would be calculated using the same distributed approach for data collection proposed for operating risk adjustment on behalf of states. The intent was to permit issuers to receive reinsurance payments using the same systems established for the risk adjustment program, resulting in less administrative burden and lower costs, while maintaining the security of identifiable health information.

The major changes in the proposed rule from the policies in the Premium Stabilization Rule were:

- Uniform reinsurance payment parameters to be used by all states;
- A uniform reinsurance contribution collection and payment calendar;
- A one-time annual reinsurance contribution collection, instead of quarterly collections in a benefit year;
- Collection of reinsurance contributions by HHS under the national contribution rate from both health insurance issuers and self-insured group health plans;
- A limitation on states’ ability to change reinsurance payment parameters from those that HHS establishes in the annual HHS notice of benefit and payment parameters. A state may only propose supplemental reinsurance payment parameters if the state elects to collect additional funds for reinsurance payments or use additional state funds for reinsurance payments; and
- A limitation on states that seek additional reinsurance funds for administrative expenses, such that the state must have its applicable reinsurance entity collect those additional funds.

HHS has finalized some of these provisions without changes, and some with modifications, as described below.

1. State Standards Related to the Reinsurance Program

a. State Standards Related to the Reinsurance Program (§153.100, §153.110, §153.210)

Under revised §153.100, states would not be permitted to modify the federal schedule via a state notice of benefit and payment parameters. Instead, the frequency with which data would have to be submitted for reinsurance payments would follow a national schedule. HHS would, however, continue to allow a state establishing a reinsurance program to modify the data requirements for health insurance issuers to receive reinsurance payments, provided that the state publishes a state notice of benefit and payment parameters and specifies these modifications in that notice. A state that elected to collect additional reinsurance contributions for purposes of making additional reinsurance payments or use additional funds for reinsurance payments under §153.220(d) would be required to publish supplemental state reinsurance payment parameters in its state notice of benefit and payment parameters.

HHS further proposed to collect reinsurance contributions on behalf of all states from both health insurance issuers and self-insured group health plans in the aggregate, and to disburse reinsurance payments based on a state's need for reinsurance payments, not based on where the contributions were collected. As a result, HHS would no longer be able to attribute additional funds for administrative expenses back to a state. Section 153.100(a)(3) would be amended to clarify that these additional contributions may only be collected by a state operating its own reinsurance program in that state. Related changes would be made to enable HHS to disperse reinsurance contributions in proportion to the need for reinsurance payments (see proposed changes to §153.110(d)(5) and §153.210(a)(2)(iii) as well as deletion of §153.110(d)(2)).

HHS also proposed to collect all contributions under a national contribution rate from all health insurance issuers in all states. This required deleting all requirements regarding the state collection of reinsurance contributions from issuers under the national contribution rate, including §153.100(a)(2) and §153.110(b), and removing the requirement that a state publish a state notice of benefit and payment parameters to announce its intention to collect reinsurance contributions from issuers. Also deleted would be §153.110(d)(4) requiring states to publish in their notices an estimate of the reinsurance contributions to be collected by each applicable reinsurance entity.

Final Rule. HHS is finalizing these provisions as proposed with a technical amendment to §153.210(a)(2) in which it clarifies that a state's obligation to ensure that each applicable reinsurance entity operates in a distinct geographic area applies regardless of whether the state contracts with or establishes the applicable reinsurance entities. As clarified later, governmental entities may serve as applicable reinsurance entities. HHS is also making technical changes to subparts of §153.100, §153.110; and §153.400.

In response to a commenter's question whether HHS will implement an approval process for states choosing to operate reinsurance, similar to the process used to approve states choosing to

operate the risk adjustment program. HHS says that there will be no formal approval process for state-operated reinsurance programs. However, HHS will establish a consultative pre-implementation process to ensure that each state that is operating reinsurance is ready to operate beginning in 2014.

HHS also reports that based on its communications with states, as of February 25, 2013, Maryland and Connecticut are the only states electing to operate reinsurance for 2014.

b. Reporting to HHS (§153.210; §153.240)

HHS had proposed to add to a new subsection (e) to §153.210 to require each state that established a reinsurance program to ensure that each applicable reinsurance entity provide information regarding requests for reinsurance payments under the national contribution rate for all reinsurance-eligible plans for each quarter during the applicable benefit year in a manner and timeframe established by HHS. This information would be used to monitor requests for reinsurance payments and contribution amounts throughout the benefit year in order to ensure equitable reinsurance payments in all states. Under proposed §153.240(b)(2), a state, or HHS on behalf of the state, would be required to provide issuers of reinsurance-eligible plans with quarterly estimates of the expected requests for reinsurance payments under both the national payment parameters and any state supplemental payments parameters, as determined by HHS or the state's reinsurance entity, as applicable. These quarterly estimates would provide issuers of individual coverage with the timely information needed to support the calculation of expected claims assumptions that are key to rate development and ultimately, premium stabilization. HHS noted its expectation that reinsurance payments would be used in the rate setting process by issuers to reduce premiums.

Final Rule. HHS has finalized these provisions as proposed, with modifications in §153.240(b)(2) to clarify that a state must provide to an issuer of a reinsurance-eligible plan the calculation of the total reinsurance payments requested under the national reinsurance payment parameters and state supplemental reinsurance payment parameters, on a quarterly basis during the applicable benefit year in a timeframe and manner determined by HHS. In response to commenters' suggestions about quarterly reporting, HHS says that it expects to issue guidance for states and issuers regarding this activity.

c. Additional State Collections and d. State Collections (§153.220)

Under proposed §153.220(d), if a state established a reinsurance program: (1) The state could elect to collect more than the amounts that would be collected based on the national contribution rate set forth in the annual HHS notice of benefit and payment parameters for the applicable benefit year to provide: funding for administrative expenses of the applicable reinsurance entity; or additional funds for reinsurance payments. (2) The state would have to notify HHS within 30 days after publication of the draft annual HHS notice of benefit and payment parameters for the applicable benefit year of the additional contribution rate that it elects to collect for any additional contributions. (3) A state could use additional funds which were not collected as additional reinsurance contributions for reinsurance payments under the state supplemental payment parameters under §153.232. This would allow states to use other revenue sources,

including funds for their high-risk pools (see below), for supplemental reinsurance payments. Additional conforming changes were proposed. HHS emphasized that a state cannot collect from self-insured group health plans covered by ERISA.

Final Rule. HHS has finalized these provisions as proposed with the following modification: it has deleted §153.220(d)(2), which required a state to notify HHS within 30 days after publication of the draft annual HHS notice of benefit and payment parameters for the applicable benefit year of the additional contribution rate that it elects to collect. Any state operating reinsurance and electing to collect additional contributions under §153.220(d) must set forth any additional contribution rate that it elects to collect in its state notice of benefit and payment parameters.

e. High-Risk Pools

In the proposed rule's preamble, HHS noted that it was not proposing further requirements for state high-risk pools beyond those currently provided at §153.250. Under that provision, a state must eliminate or modify its high-risk pool to the extent necessary to carry out the transitional reinsurance program but such changes must comply with the terms and conditions of federal grants to states for operation of qualified high-risk pools. Further, the ACA permits a state to coordinate its high-risk pool with the reinsurance program "to the extent not inconsistent" with the statute. Thus, a state may coordinate the entry of the state's high-risk pool enrollees into the Exchange. HHS clarified that nothing in the Premium Stabilization Rule prevents a state that establishes its own reinsurance program from using state money designated for its own high-risk pool towards the reinsurance program. However, a state may not use funds collected for the reinsurance program for its high-risk pool. Finally, a state could designate its high-risk pool as its applicable reinsurance entity, provided that the high-risk pool met all applicable criteria for being an applicable reinsurance entity.

Final Rule. In the preamble to the final rule, HHS responds to comments requesting it to permit state high-risk pools to be eligible for reinsurance payments for their high-risk enrollees, that they are not eligible for such payment because high-risk pool coverage is not individual market coverage. If it were structured as individual market coverage subject to the market reform rules, it would be eligible for reinsurance payments and would also, therefore, be a contributing entity. HHS also clarifies that states have the flexibility to decide whether to maintain, phase-out, or eliminate their high-risk pools.

2. Contributing Entities and Excluded Entities (§153.400)

Under §1341 of the ACA, health insurance issuers and third party administrators on behalf of group health plans must make payments to an applicable reinsurance entity. Thus, with respect to insured coverage, issuers are liable for making reinsurance contributions. With respect to self-insured group health plans, the plan is liable (and pays directly), although a third-party administrator or administrative-services-only (ASO) contractor may be utilized to transfer reinsurance contributions on behalf of a self-insured group health plan, at that plan's discretion. Contribution amounts for reinsurance are to reflect, in part, an issuer's "fully insured commercial book of business for all major medical products." In the proposed rule's preamble, HHS said that it is implicit in the ACA that contributions are not required for health insurance coverage that is

not regulated by a state department of insurance and written on a policy form filed with and approved by a state department of insurance (but contributions are generally required for self-insured plans even though they are not regulated by a state department of insurance). In this section of the proposed and now final rule, HHS describes its policy to exclude certain types of plans.

Final Rule. The proposed rule is adopted with some changes. Under the final rule, HHS makes clear that a contributing entity must make reinsurance contributions for its self-insured group health plans and health insurance coverage except to the extent that: (i) such plan or coverage is not major medical coverage; (ii) in the case of health insurance coverage, such coverage is not considered to be part of an issuer's commercial book of business; (iii) such plan or coverage is expatriate health coverage, as defined by the Secretary; or (iv) in the case of employer-provided coverage, such coverage applies to individuals with respect to which benefits under Medicare are primary under the Medicare Secondary Payer rules and their regulations. (HHS has added the expatriate coverage and made other clarifying changes to the above.)

A contributing entity is not required to make contributions on behalf of the following: a self-insured group health plan or coverage that consists solely of excepted benefits as defined by §2791(c) of the PHS Act, Medicare; Medicaid, CHIP, federal or state high-risk pool, including the Pre-existing Condition Insurance Plan Program; ACA Basic health plan coverage; a Health Reimbursement Arrangement (HRA); a Health Savings Account (HSA); a flexible spending arrangement (under section 125 of IRC); and other plans as specified (see §153.400(a)(2)). In the final rule, HHS has added to this list “a self-insured group health plan or health insurance coverage that consists solely of benefits of prescription drugs.”

In response to comments, HHS clarifies that if a high-risk pool were structured as individual market coverage subject to the market reform rules, it would be eligible for reinsurance payments and would also, therefore, be a contributing entity. HHS advises that it will provide details on the process for submission of reinsurance contributions in future guidance. (For additional discussion of the excepted types of coverage from being a contributing entity, see 78 *FR* 15456-15459 of the final rule's preamble. Other types of policies that some advocated for exceptions from reinsurance contributions but that are not (e.g., Taft-Hartley plans) are also addressed.)

3. National Contribution Rate

a. 2014 Contribution Rate

In the preambles to the proposed and final rules, HHS reiterates that the total contribution amounts required to be collected by the ACA from contributing entities (i.e., the reinsurance pool) are: \$10 billion in 2014, \$6 billion in 2015, and \$4 billion for 2016. Out of these amounts, \$2 billion in 2014, \$2 billion in 2015, and \$1 billion for 2016 are payable to the U.S. Treasury (the same amount appropriated by the ACA for the Early Retiree Reinsurance Program). The ACA also allows for the collection of additional amounts for reinsurance program administrative expenses. Taken together, these three components make up the total dollar amount to be

collected from contributing entities for each of the three years of the reinsurance program under the national per capita contribution rate.

Under the proposed rule, the national per capita contribution rate would be calculated by dividing the sum of the three amounts (the national reinsurance pool, the U.S. Treasury contribution, and administrative costs) by the estimated number of enrollees in plans that must make reinsurance contributions.

The *national per capita reinsurance contribution rate* =

$$\frac{\text{National reinsurance pool} + \text{Treasury contribution} + \text{administrative costs}}{\text{Estimate of enrollees in plans required to make reinsurance contributions}}$$

The following example was provided for 2014—

National reinsurance pool = \$10 billion
 Contribution to the U.S. Treasury = \$2 billion.
 Collection for administrative expenses = \$20.3 million (0.2% of the \$10 billion dispersed) (see below)
 Total = \$12.023 billion
 For the HHS estimated number of enrollees in plans required to make reinsurance contributions = the per capita per month contribution is \$5.25

As required under §153.220(c) (previously designated as §153.220(e)), HHS proposed that the national contribution rate and the proportion of contributions collected under the national contribution rate be allocated to reinsurance payments, payments to the U.S. Treasury, and administrative expenses.

| Proportion of Contributions Collected under the National Contribution Rate for Reinsurance Payments, Payments to the U.S. Treasury and Administrative Expenses | | |
|---|--|--|
| Proportion or amount for: | If total contribution collections under the national contribution rate are less than or equal to \$12.02 billion | If total contribution collections under the national contribution rate are more than \$12.02 billion |
| Reinsurance payments | 83.2% (\$10 billion/\$12.02 billion) | The difference between total national collections and those contributions allocated to the US Treasury and administrative expenses |
| Payments to the U.S. Treasury | 16.6% (\$2 billion/\$12.02 billion) | \$2 billion |
| Administrative expenses | 0.2% (\$20.3 million/\$12.012 billion) | \$20.3 million |
| See Table 20, 78 FR 15460. | | |

Final Rule. HHS is finalizing these provisions as proposed, including the monthly per capita contribution rate of \$63.00 in benefit year 2014 or \$5.25 per month. (See above table, unchanged in content from the table in the proposed rule.) HHS notes that comments varied, some in support

of the national contribution rate whereas others argued that a national rate would penalize states with lower medical costs and require those states to subsidize other states with higher medical costs. HHS says in response that the national, per capita rate was chosen because it is a simpler approach that minimizes the administrative burden of collections. Also in response to requests, HHS provides information on the assumptions behind the enrollment estimates that were used to calculate the national contribution rate for 2014 (see 78 *FR* 15461).

In response to requests for clarification on whether the reinsurance contributions may be charged back to an ERISA plan as a reasonable plan expense and whether the IRS had indicated that the reinsurance contribution is tax-deductible as an ordinary and necessary business expense, HHS reports that the Department of Labor has advised HHS that paying reinsurance contributions would constitute a permissible expense of the plan for purposes of Title I of ERISA because the payment is required by the plan under the ACA. (For a discussion of the tax status of reinsurance contributions pursuant to the ACA, see the IRS' FAQ at: www.irs.gov/uac/Newsroom/ACA-Section-1341-Transitional-Reinsurance-Program-FAQs).

b. Federal Administrative Fees

HHS had proposed a national per capita contribution rate of \$0.11 annually for HHS administrative expenses. HHS explained that if it operated the reinsurance program on behalf of a state, it would retain the annual per capita administrative fee. If a state operated its own program, HHS would transfer \$0.055 (half) of the per capita fee to the state so that it could be used for the state's administrative expenses; HHS would retain the remaining \$0.055 to offset the costs of contribution collection. The administrative expenses for reinsurance payments would be distributed in proportion to the state-by-state total requests for reinsurance payments made under the national payment parameters.

Final Rule. HHS has finalized these provisions as proposed. The total cost for HHS to operate reinsurance on behalf of states for 2020 will be \$20.3 million or \$0.11 per capita per year. In response to comments, HHS notes that it determined the total costs to HHS for administering reinsurance on behalf of states by examining its contract costs of operating reinsurance (the contracts cover collections, payments, account management, data collection, program integrity, operational and fraud analytics, stakeholder training and operational support). The cost of federal personnel was not included. It divided HHS' projected total costs for administering reinsurance on behalf of states by the expected enrollment in health insurance plans and self-insured group health plans.

4. Calculation and Collection of Reinsurance Contributions

a. Calculation of Reinsurance Contribution Amounts and Timeframe for Collection (§153.405)

HHS' goal in administering the reinsurance program is to minimize the administrative burden on issuers and self-insured group health plans, while ensuring that contributions are calculated accurately. Under proposed §153.400(a) and §153.240(b)(1), HHS would collect and pay out reinsurance funds annually as opposed to throughout the benefit year.

To clarify how issuers and self-insured group health plans would be assessed for reinsurance contributions, HHS had proposed to add §153.405. The contribution would be calculated by multiplying the average number of covered lives of reinsurance contribution enrollees during the benefit year for all of the entity's plans and coverage that must pay reinsurance contributions, by the national contribution rate for the applicable benefit year. In addition, §153.405(b) would be amended to require that, no later than November 15 of benefit year 2014, 2015, and 2016, as applicable, a contributing entity would have to submit to HHS an annual enrollment count of the average number of covered lives of reinsurance contribution enrollees for each benefit year. The count would have to be determined as specified in proposed §153.405(d), (e), (f), or (g) as applicable. Section 153.400(a) would be amended so that each contributing entity would be required to make reinsurance contributions at the national contribution rate annually and in a manner specified by HHS. Additional regulation text would be added to implement the requirement that entities make contributions annually and in a manner specified by HHS. If a state elected to collect additional contributions, the entity would be required to make the contributions annual and in a manner specified by the state.

Under proposed §153.405(c)(1), within 15 days of submission of the annual enrollment count or by December 15, whichever was later, HHS would notify each contributing entity of the reinsurance contribution amounts to be paid based on that annual enrollment count. The contributing entity would be required to remit contributions to HHS within 30 days after the date of the notification of contributions due for the applicable benefit year.

Final Rule. HHS finalizes these provisions as proposed with technical corrections:

- §153.400 – clarifies that each contributing entity must make reinsurance contributions annually at the national contribution rate.
- §153.405(c) – clarifies that HHS will notify a contributing entity of reinsurance contributions amounts to be paid for a benefit year by the later of December 15 or 30 days after the submission of the annual enrollment count; and
- §153.405(a)(1), §153.405(b) and §153.405(d) – HHS deletes “average” to clarify that reinsurance contributions are calculated by multiplying the number of covered lives of reinsurance contribution enrollees during the applicable benefit year for all contributing entities by the national contribution rate, pursuant to §153.405(a).

HHS also notes in response to comments that any unused funds collected for 2014 will be used for reinsurance payment parameters for subsequent benefit years.

Counting Methods for Health Insurance Issuers. In §153.405(d), HHS proposed three distinct methods that an issuer could use to determine the average number of covered lives of reinsurance contribution enrollees under a plan for a benefit year for purposes of the annual enrollment count. HHS noted that “These methods promote administrative efficiencies by building on the methods permitted for purposes of the fee to fund the Patient-Centered Outcomes Research Trust Fund (the PCORTF Rule), modified so that a health insurance issuer may determine an annual enrollment count during the fourth quarter of the benefit year. Thus, under each of these methods, the number of covered lives will be determined based on the first nine months of the benefit year.”

Counting Methods for Self-Insured Group Health Plans. In §53.405(e), HHS proposed three methods that a self-insured group health plan could use to determine the average number of covered lives for purposes of the annual enrollment count.

Counting Methods for Plans with Self-insured and Insured Options. HHS noted in the preamble to the proposed rule that an employer may sponsor a group health plan that offers one or more coverage options that are self-insured and one or more other coverage options that are insured. In §153.405(f), it proposed that to determine the number of covered lives of reinsurance contribution enrollees under a group health plan with both self-insured and insured options for a benefit year, the plan use the “actual count” method or “snapshot count” for health insurance issuers, both of which were defined in the proposed rule.

Aggregation of Self-insured Group Health Plans and Health Insurance Plans. In §153.405(g)(1), HHS proposed that if a plan sponsor maintained two or more group health plans or health insurance plans (or a group health plan with both insured and self-insured components) that collectively provided major medical coverage for the same covered lives, (“multiple plans”), then these plans would have to be treated as a single self-insured group health plan for purposes of calculating any reinsurance contribution amount due. The plan sponsor would be responsible for paying the applicable fee. The term “plan sponsor” was defined for different types of entities (e.g., single employer, employee organization, multiple employer welfare arrangement, etc.).

Exceptions. HHS proposed two exceptions to this aggregation rule in §153.405(g)(3). (1) If the benefits provided by any health insurance or self-insured group health plans were limited to excepted benefits (such as stand-alone dental or vision benefits), the excepted benefits coverage need not be aggregated with other plans for purposes of this section. (2) If benefits provided by any health insurance or self-insured group health plan were limited to prescription drug coverage, that coverage need not be aggregated so as to reduce the burden on sponsors who have chosen to structure their coverage in that manner. Thus, if enrollees had major medical coverage and separate coverage consisting of prescription drug or excepted benefits, reinsurance contributions only would be required with respect to the major medical coverage.

Other Plan Configurations. HHS proposed counting requirements for: multiple plans in which at least one of the plans is an insured plan and there also are multiple self-insured group health plans not including an insured plan; multiple group health plans including an insured plan; and multiple self-insured group health plans not including an insured plan.

Consistency with PCORTF Rule Not Required. HHS said in the proposed rule’s preamble that it intended to allow a reinsurance contributing entity to use a different counting method for the annual enrollment count of covered lives for purposes of reinsurance contributions from that used for purposes of the return that is required in connection with the PCORTF Rule.

Final Rule. In response to comments, HHS has finalized these provisions as proposed, with some modifications, including technical adjustments to the aggregation rules set forth in §153.405:

- Provides plan sponsors with the option to count any coverage options within a single group health plan separately if the coverage options are treated as offering major medical coverage;
- Provides plan sponsors with the option not to aggregate group health plans for purposes of counting covered lives if each group health plan is treated as offering major medical coverage; and
- Includes HRAs, HSAs, and FSAs in the categories of group health plans that are excluded from the counting rules.

In response to commenters' concerns about the process for submitting enrollment counts and contributions, HHS advises that it will provide details on these processes in future guidance.

b. State Use of Contributions Attributed to Administrative Expenses

In the proposed rule, HHS outlined three restrictions that it intended to propose on the use of reinsurance contributions for administrative expenses in order to permit states that participate in the reinsurance program to accurately estimate the cost of administrative expenses. (Details of these standards would be provided in future regulation and guidance.) First, such funds could not be used for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative or regulatory modifications. Second, they could not be used for any expense which was not necessary to the operation and administration of the reinsurance program. Finally, an applicable reinsurance entity would have to allocate any shared, indirect, or overhead costs between reinsurance-related and other state expenses based on generally accepted accounting principles, consistently applied. An applicable entity would be required to provide HHS, in a timeframe and manner specified by HHS, a report setting forth and justifying its allocation of administrative costs.

Final Rule. HHS did not receive any comments on this section. It intends to issue future rulemaking to address the issues noted above.

5. Eligibility for Reinsurance Payments under Health Insurance Market Rules (§153.234)

HHS had proposed to add §153.234 to clarify that, under either the reinsurance national payment parameters or the state supplemental reinsurance payment parameters, if applicable, a reinsurance-eligible plan's covered claims costs for an enrollee incurred prior to the application of the ACA's 2014 market reform rules did not count toward either the national or state supplemental attachment points, reinsurance caps, or coinsurance rates. The market reform rules would be effective for the individual market for policy years beginning on or after January 1, 2014, and as a result, policies issued in 2013 would be subject to these rules at the time of renewal in 2014, and therefore, would become eligible for reinsurance payments at the time of renewal in 2014.

HHS also proposed that state-operated reinsurance programs similarly limit eligibility for reinsurance payments. This policy contrasted with HHS' proposed approach for state-operated risk adjustment programs under which states would be permitted to choose to risk adjust plans not subject to the 2014 market reform rules. This is because permitting state flexibility on the

applicability of risk adjustment to plans not subject to the 2014 market reform rules would further the goals of the risk adjustment program but state flexibility for eligibility for reinsurance payments would not further the goal of the reinsurance program.

HHS noted too its intent to operate the reinsurance program on a calendar year basis, drawing its policy from its reading of the ACA.

Final Rule. HHS has adopted these proposed provisions as final without change.

6. Reinsurance Payment Parameters

HHS restates in the final rule's preamble the requirement in the Premium Stabilization Rule that reinsurance payments to eligible issuers be made for a portion of an enrollee's claims costs paid by the issuer that exceeds an attachment point, subject to a reinsurance cap. The coinsurance rate, attachment point, and reinsurance cap are the reinsurance "payment parameters." The ACA directs the Secretary, in establishing transitional reinsurance program standards to include a formula for determining the amount of reinsurance payments to be made to issuers for high-risk individuals that provides for the equitable allocation funds. Using the Secretary's authority under this provision, HHS had proposed to amend its policy by establishing uniform "national" reinsurance payment parameters that would be applicable to the reinsurance program for each state, whether or not operated by a state. The rationale was that such national parameters would provide for equitable access to the reinsurance funds across states, while furthering the goal of premium stabilization across all states by disbursing reinsurance contributions where they are most needed.

HHS proposed the following 2014 national payment parameters:

- Reinsurance to begin at an attachment point of \$60,000
- Reinsurance program stops paying claims for a high-cost individual at \$250,000 (i.e., the reinsurance cap)
- 80% uniform coinsurance rate (meant to reimburse a proportion of claims between the attachment point and reinsurance cap while giving issuers an incentive to contain costs).

HHS said that these proposed payment parameters would help offset high-cost enrollees, without interfering with traditional commercial reinsurance, which typically has attachment points in the \$250,000 range.

HHS estimated that these national payment parameters would result in total requests for reinsurance payments of approximately \$10 billion. It continued to monitor individual market enrollment and claims patterns to appropriately disburse reinsurance payments throughout each of the benefit years.

HHS explained in the preamble's proposed rule how it developed a model that estimates market enrollment incorporating the effects of state and federal policy choices and accounting for the behavior of individuals and employers (the Affordable Care Act Health Insurance Model (ACA-HIM)). The outputs of the ACA-HIM, especially the estimated enrollment and expenditure

distributions, were used to analyze a number of policy choices relating to benefit and payment parameters, including the national reinsurance contribution rate and national reinsurance payment parameters. The ACAHIM (including the data and assumptions used about key variables such as take-up of insurance) was described in the preamble in two sections: (1) the approach for estimating 2014 enrollment and (2) the approach for estimating 2014 expenditures (77 FR 73160).

Final Rule. HHS finalizes the proposed payment parameters and the associated payment provisions proposed in §153.230(a) through §153.230(c), with a technical revision in §153.230(a) changing “non-grandfathered individual market plan” to “reinsurance-eligible plan” and clarifying in §153.230(c) that national reinsurance payments are calculated as the product of the national coinsurance rate multiplied by the health insurance issuer’s claims costs for an individual enrollee’s covered benefits that the health insurance issuer incurs in the applicable benefit year.

Although some commenters supported the proposal, many urged that states be able to set their own payment parameters using state contributions to better target their local markets. HHS says in response that the uniform payment parameters best meet the reinsurance’s program goals to promote premium stabilization and market stability in all states, consistent with statutory intent. HHS aims to administer the program in an efficient, fair, and accurate manner so that reinsurance funds are allocated equitably and can maximize downward pressure on premiums.

HHS notes also that a state, or HHS on behalf of the state, will provide each reinsurance-eligible plan the expected requests for reinsurance payments made under the national payment parameters and state supplemental parameters, if applicable. These reports can provide the information necessary for issuers to set rates in subsequent benefit years

7. Uniform Adjustment to Reinsurance Payments (§153.230)

HHS proposed to amend §153.230 by specifying in subparagraph (d) that HHS would adjust reinsurance payments by a uniform, pro rata adjustment rate in the event that HHS determined that the amount of total requests for reinsurance payments under the national reinsurance payment parameters would exceed the amount of reinsurance contributions collected under the national contribution rate during a given benefit year. The total amount of contributions considered for this purpose would include any contributions collected but unused under the national contribution rate during any previous benefit year. If HHS determined that the total reinsurance contributions collected under the national contribution rate for the applicable benefit year were equal to or more than the total requests for reinsurance payments calculated using the national reinsurance payment parameters, then no such adjustment would be applied, and all requests for reinsurance payments would be paid in full under the national payment parameters.

Final Rule. HHS has finalized this section as proposed.

HHS offers a clarification on the question of when, if necessary, the uniform adjustment to national reinsurance payments set forth in §153.230(d) would occur, and how HHS will disburse reinsurance funds to states operating reinsurance, in order for the states to make reinsurance

payments. HHS says in response that as described in §153.235, it plans to allocate and disburse to each state operating reinsurance (and will distribute directly to issuers if HHS is operating reinsurance on behalf of a state), reinsurance contributions collected from contributing entities under the national contribution rate for reinsurance payments. The disbursed funds would be based on the total requests for reinsurance payments made under the national reinsurance payment parameters by all states and submitted under §153.410, net of any adjustment under §153.230(d). Thus, prior to the disbursement, HHS would uniformly adjust reinsurance payments, if applicable, following the collection of contributions and after the receipt of all claims for reinsurance payments, which must be submitted by April 30 of the year following the applicable benefit year. Following that adjustment, HHS will make reinsurance payments in states where HHS is operating reinsurance on behalf of the state, and will distribute funds to states operating reinsurance.

8. Supplemental State Reinsurance Parameters (§153.232)

HHS had proposed in a new §153.232(a) that a state that establishes its own reinsurance program could only modify the national reinsurance parameters by establishing state supplemental payment parameters that cover an issuer's claims costs beyond the national reinsurance payment parameters. In addition, reinsurance payments under these supplemental payments parameters could only be made with additional funds the state collected for reinsurance payments under §153.220(d)(1)(ii) or state funds applied to the reinsurance program under §153.220(d)(3). A state could set its supplemental reinsurance payments parameters by adjusting the national reinsurance payment parameters in one or more of the following ways: (1) decreasing the national attachment point; (2) increasing the national reinsurance cap; or (3) increasing the national coinsurance rate. In other words, a state would not be permitted to alter the national reinsurance payment parameters in a manner that could result in reduced reinsurance payments.

HHS further proposed that a state ensure that any additional funds for reinsurance payments it collected or state funds (otherwise collected) were reasonably calculated to cover additional reinsurance payments that were projected to be made under the state's supplemental reinsurance payment parameters for a given benefit year. The state also would have to ensure that such parameters were applied to all reinsurance eligible plans in that state in the same manner. CMS further proposed that contributions collected or additional funds, as applicable, be applied toward requests for reinsurance payments made under the state supplemental reinsurance payments parameters for each benefit year commencing in 2014 and ending in 2016.

Under proposed §153.232(c), an issuer of a non-grandfathered individual market plan would become eligible for reinsurance payments under a state's supplemental reinsurance parameters if its incurred claims costs for an individual enrollee's covered benefits during a benefit year: (1) exceeded the supplemental state attachment point; (2) exceeded the national reinsurance cap; or (3) exceeded the national attachment point, if the state had established a state supplemental coinsurance rate. HHS explained that this would allow reinsurance payments made under the state supplemental payment parameters to "wrap around" the national reinsurance payment parameters so that the state could apply any additional contributions it collects under proposed §153.220(d) towards reinsurance payments beyond the national reinsurance payment parameters. In this way, "HHS can distribute funds under the national payments formula to where they are

needed most, while allowing States that elect to run their own program the flexibility to supplement nationally calculated reinsurance payments.” States would be required to separate in their reporting to issuers the reinsurance payments paid under the national and state supplemental parameters.

To ensure that reinsurance payments under state supplemental payment parameters did not overlap with the national parameters, HHS proposed in §153.232(d) a method for calculating state supplemental reinsurance payments. The method was explained, with an example, in the proposed rule’s preamble at 77 *FR* 73161.

HHS also proposed in §153.232(e) that if all requested reinsurance payments under the state parameters calculated in a state for a benefit year would exceed all the additional funds a state collects for reinsurance payments, the state would have to determine a uniform pro rata adjustment to be applied to all such requests for reinsurance payments. Each applicable reinsurance entity in the state would have to reduce all such requests for reinsurance payments by that adjustment.

Under proposed §153.232(f), a state would have to ensure that reinsurance payments made to issuers under the state parameters did not exceed the issuer’s total paid amount for the reinsurance-eligible claim(s) and any remaining additional funds collected were used for reinsurance payments under the state supplemental parameters in subsequent benefit years.

Final Rule. HHS is finalizing these provisions as proposed, with a technical correction. It has changed “non-grandfathered individual market plan” to “reinsurance-eligible plan” and, in §153.232(c), clarified that the incurred claims costs for an individual enrollee’s covered benefits are those incurred in the applicable benefit year. In §153.232(d), HHS clarifies that reinsurance payments will be calculated with respect to an issuer’s incurred claims costs for an individual enrollee’s covered benefits incurred in the applicable benefit year.

Although several commenters urged HHS to allow additional state flexibility for the state supplemental reinsurance payment parameters, others urged flexibility for a state to design a program that would cover any shortfall in payments under the reinsurance program’s uniform parameters. HHS says in response that although state flexibility is one of its goals, it also wants to ensure consistency with the policy goals of the reinsurance program. Under these final rules, it therefore has provided states with the flexibility to increase the coinsurance rate on reinsurance-eligible claims, which would have the effect of increasing payouts under the uniform parameters. It further advises that nothing in these final rules prevents a state from establishing a separate program that would operate alongside the ACA reinsurance program. A state is free to implement the collections methodology and payment formula of its own choosing.

9. Allocation and Distribution of Reinsurance Collections (§153.220(a), §153.235(a))

Under §153.220(d) of the Premium Stabilization Rule, HHS would distribute reinsurance contributions collected for reinsurance payments from a state to the applicable reinsurance entity for that state. Under the proposed rule, this would have been replaced with §153.235(a). Under that proposed section, HHS would allocate and distribute the reinsurance contributions collected

under the national contribution rate based on the need for reinsurance payments, regardless of where the contribution was collected. As noted earlier, HHS would then disburse all contributions collected under the national contribution rate from all states for the applicable benefit year, based on all available contributions and the aggregate requests for reinsurance payments, net of the pro rata adjustment, if any. Consistent with this proposal, §153.220(a) would be amended to clarify that even if a state established a reinsurance program, HHS would directly collect from health insurance issuers, as well as self-insured group health plans, the reinsurance contributions for enrollees who reside in that state.

Final Rule. HHS has finalized the provisions as proposed in §153.220(a). It has revised §153.235(a) to provide that HHS will allocate and disburse to each state operating reinsurance (and will distribute directly to issuers if HHS is operating reinsurance on behalf of a state), reinsurance contributions collected from contributing entities under the national contribution rate for reinsurance payments. The disbursed funds will be based on the total requests for reinsurance payments made under the national reinsurance payment parameters in all states and submitted under §153.410, net of any adjustment under §153.230(d). HHS has amended §153.410(a) to clarify that an issuer of a reinsurance-eligible plan may make requests for reinsurance payments when an issuer's claims costs for an enrollee of that reinsurance-eligible plan has met the criteria for reinsurance payments in 45 CFR subpart B and this final rule and, where applicable, the state notice of benefit and payment parameters.

Some commenters said that the proposed allocation of reinsurance payments would penalize states that effectively and efficiently manage health care costs and have fewer uninsured individuals. Some also said that it went against the state-based nature of the reinsurance program intended by the statute. HHS responds that its allocation is more consistent with the goal of maximizing the program's impact on premium rates, a goal of the ACA's reinsurance provisions. In response to recommendations that HHS refund any uninsured contributions collected or use those funds to lower contribution rates in subsequent years, HHS says that if any funds remain, it plans to use them for reinsurance payments in subsequent years.

In response to requests for clarification on the process by which HHS plans to ensure that reinsurance funds will be used to reduce and stabilize premiums in the individual market, HHS says that it expects that an issuer that receives reinsurance payments will reduce premiums in the individual market accordingly. When the issuer receives from the state or HHS the estimated amount of the reinsurance payments throughout a benefit year, it can account for the reinsurance payments in developing its premium for subsequent benefit years. HHS notes that under the single risk pool requirement of the final Market Reform Rule (§156.80), issuers of non-grandfathered individual market plans must adjust their index rate based on the total expected market-wide payments and charges under the risk adjustment and reinsurance programs in the state, and based on Exchange user fees.

In response to queries about how HHS will distributed excess reinsurance funds after 2016, HHS says that it will provide details in future rulemaking and guidance.

10. Reinsurance Data Collection Standards for Reinsurance Payments

a. Data Collection Standards for Reinsurance Payments (§153.240(a))

Under current §153.240(a), a state's applicable reinsurance entity is directed to collect data needed to determine reinsurance payments. Under the proposed rule, a new subparagraph would be added to direct a state to ensure that its applicable reinsurance entity either collect or be provided access to the data necessary to determine reinsurance payments from an issuer of a reinsurance-eligible plan. The proposed amendment would clarify that an applicable reinsurance entity may either use a distributed data collection approach for its reinsurance program or directly collect privacy-protected data from issuers to determine an issuer's reinsurance payments. Additional language would be added to direct states to provide a process through which an issuer of a reinsurance-eligible plan that does not generate individual enrollee claims may use estimated claims costs to make a request for payment. Such requests for reinsurance payment would be subject to validation. HHS explained that this proposed amendment would enable certain reinsurance-eligible plans, such as staff-model health maintenance organizations, that do not generate claims with associated costs in the normal course of business to provide data to request and receive reinsurance payments.

Final Rule. HHS finalized this provision as proposed.

b. Notification of Reinsurance Payments (§153.240(b))

HHS had proposed to add a new §153.240(b)(1) directing a state, or HHS on behalf of the state, to notify issuers of the total amount of reinsurance payments that would be made no later than June 30 of the year following the benefit year (the same date on which a state or HHS would have to notify issuers of risk adjustment payments and charges). In other words, by June 30 of the year following the applicable benefit year, issuers would be notified of both reinsurance payments and risk adjustment payments and charges. This would allow issuers to account for their total reinsurance payments and risk adjustment payments and charges when submitting data for the risk corridors and minimum medical loss ratio (MLR) programs. To provide individual market issuers with information to assist in development of premiums and rates in subsequent benefit years, proposed §153.240(b)(2) directed a state to provide quarterly notifications of estimates to each reinsurance-eligible plan of the expected requests for reinsurance payments for each quarter. HHS said that it would collaborate with issuers and states to develop these early notifications.

Final Rule. HHS is finalizing this provision as proposed. It responds to queries about when it would issue payments by saying that they would be issued as quickly as possible but anticipates issuing further guidance on this issue.

c. Privacy and Security Standards (§153.240(d))

HHS had proposed to amend §153.240 by adding paragraph (d)(1) to require a state operating its own reinsurance program to ensure that the applicable reinsurance entity's collection of personally identifiable information was limited to information reasonably necessary for use in

the calculation of reinsurance payments and that use and disclosure of personally identifiable information was limited to those purposes for which the personally identifiable information was collected (including for purposes of data validation). HHS explained that this proposal aligned with corresponding language for the risk adjustment program. Further, proposed new paragraph (d)(2) would require that an applicable reinsurance entity provide administrative, physical, and technical safeguards for personally identifiable information that may be used to request reinsurance payments. This was meant to ensure that an applicable reinsurance entity complies with the same privacy and security standards that apply to issuers and providers.⁷

Final Rule. HHS has finalized this provision as proposed. In response to suggestions that it provide for audits and other safeguards to protect personal health information from inappropriate disclosure, HHS says that it will provide more information on its approach to these and other oversight matters in future rulemaking.

d. Data Collection (§153.420(a) and (b))

HHS had proposed the addition of §153.420(a) to require that issuers of plans eligible for and seeking reinsurance payments submit or make accessible data (including data on cost-sharing reductions to permit the calculation of enrollees' claims costs incurred by the issuer), in accordance with the reinsurance data collection approach established by the state, or HHS on behalf of the state. Proposed §153.420(b) would direct an issuer of a reinsurance-eligible plan to submit data to be considered for reinsurance payments for the applicable benefit year by April 30 of the year following the end of the applicable benefit year.

Final Rule. HHS has finalized these provisions as proposed. In response to requests for clarification on the claims run-out period, HHS says that an issuer of a risk adjustment covered plan or reinsurance eligible plan in a state in which HHS is operating the risk adjustment or reinsurance program would submit data for a benefit year by April 30 of the year following the applicable benefit year. It gives an example and further explanation at 78 *FR* 15471-2.

D. Provisions for the Temporary Risk Corridor Program

Background

Section 1342 of the ACA, previously codified in subpart F of 45 CFR 153, sets out a temporary three-year risk corridor program designed to protect against uncertainty in rates by limiting the extent of issuer gains and losses. It provides, in general, for shared savings and losses when a QHP's allowable costs are higher or lower than a target amount. The following summarizes the thresholds and basic approach.

⁷ These standards are at §164.308, §164.310, and §164.312.

| QHP's allowable costs compared with target amount | Risk Corridor Payment |
|--|---|
| >108% | HHS pays amount equal to 2.5% of target amount + 80% of allowable costs in excess of 108% of target amount |
| >103% to ≤108% | HHS pays amount equal to 50% of target amount in excess of 103% of target amount |
| 97% to 103% | No risk corridor payment |
| ≥92% to <97% | QHP issuer pays HHS amount equal to 50% of difference between 97% of target amount and allowable costs |
| < 92% | QHP issuer pays HHS amount = 2.5% of target amount + 80% of difference between 92% of target amount and allowable costs |
| Source: Health Policy Alternatives based on §1342(b) of the ACA and §153.510 of the July 15, 2011 Notice of Proposed Rulemaking. | |

CMS finalizes several changes in the rules to reflect its previously stated intent to account for taxes and profits in the risk corridors calculation in the same manner as they are dealt with in the Medical Loss Ratio (MLR) program.

1. Definitions (§153.500)

CMS finalizes changes to the definitions necessary to account for taxes and regulatory fees and profits in the risk corridors calculation.

Taxes and regulatory fees: Federal and state licensing, regulatory fees, taxes and assessments paid with respect to a QHP as described in the MLR regulations (§158.161 and §158.162). (The final rule replaces the term “taxes” with “taxes and regulatory fees” in response to comments).

After-tax premium earned: after-tax premiums earned are premiums minus taxes and regulatory fees.

Administrative costs: total non-claims costs, including taxes and regulatory fees.

Allowable administrative costs:

- the sum of administrative costs, other than taxes and regulatory fees, plus profits;
- with that sum limited to 20 percent of after-tax premiums earned (including any premium tax credit), plus taxes and regulatory fees.

Profits: profits are the greater of:

- Three percent of after-tax premiums earned; or
- Premiums earned minus the sum of allowable costs and administrative costs.

CMS provides an example of calculation of a risk corridor payment, summarized below:

| Summary of HHS Example of Calculation of Risk Corridor Payment | |
|--|-------|
| Assumptions | |
| 1. Premiums earned | \$200 |
| 2. Allowable costs (defined in prior rule, including claims and allowed expenses for quality, information technology, and other applicable adjustments, and net of reinsurance and risk adjustment payments, and net of any cost-sharing reduction payment received by the issuer) | \$140 |
| 3. Non-claims costs, total | \$50 |
| a. Taxes | \$15 |
| b. Other than taxes | \$35 |
| Calculations | |
| 4. After tax premiums earned: premiums earned minus taxes: $(\$200 - \$15)$ | \$185 |
| 5. Profits: greater of 3% of after tax premiums earned ($3\% * \$185 = \5.55) or premiums earned minus allowable and administrative costs $(\$200 - (\$140 + \$50) = \$10)$ | \$10 |
| 6. Allowable administrative costs: sum of administrative costs other than taxes plus profits $(\$35 + \$10 = \$45)$, limited to 20% of after tax premiums earned (20% of $\$185 = \37), plus taxes $(\$15) = \$37 + \$15 = \52 | \$52 |
| 7. Target amount: premiums earned minus allowable administrative costs: $(\$200 - \$52 = \$148)$ | \$148 |
| 8. Risk corridor ratio: ratio of allowable costs to the target amount $(\$140 / \$148 = 94.6\%)$. | |
| 9. Based on risk corridor table above, issuer would be required to remit to HHS 50% of difference between 97% and 94.6% (50% of 2.4% = 1.2%) times the target amount of \$148 $(1.2\% * \$148 = \$1.78)$ | |

CMS notes, as it did in the proposed rule, that it seeks alignment between the MLR and the risk corridors program. It clarifies a number of issues in response to comments:

- Similar to the manner in which the MLR is calculated, an issuer should not consider risk corridors payments and charges when estimating taxes under the risk corridors formula.
- Reinsurance contributions are included in federal and state licensing and regulatory fees and thus are included in allowable administrative costs for risk corridors purposes. CMS is revising §153.520 and §153.530 (below) to make conforming modifications.
- The risk corridors program is not statutorily required to be budget neutral. Regardless of the balance of payments and receipts, CMS will remit payments as required.
- Non-profit entities may account for community benefit expenditures as “taxes and regulatory fees” in a manner consistent with the MLR reporting requirements for purposes of calculating the risk corridors target amount.

2. Risk corridor establishment and payment methodology (§153.510 and §153.520)

QHP issuers must remit charges to HHS within 30 days of notification of the charges. CMS notes that the schedule would align with risk adjustment, reinsurance, and MLR deadlines. By June 30 of the year following an applicable benefit year, issuers will have been notified of risk adjustment payments and charges, and all reinsurance arrangements. In the MLR section of these final rules, CMS also aligns the MLR reporting deadline to this schedule.

CMS, in response to comments, notes that:

- Allowable costs in the risk corridors program are to be reduced by any reinsurance payments received under the uniform payment parameters and any state supplemental reinsurance payment parameters.
- The statute does not provide the authority to treat reinsurance payments as an adjustment to premiums, rather than claims.

Commenters also requested that risk corridors be calculated at the issuer level rather than the QHP level, as this would be more consistent with the single risk pool requirement in the market reform rule. **CMS notes its agreement that “...a plan-level risk corridors calculation creates an incongruity with the single risk pool requirement set forth at §156.80.”**

As a result, CMS issued, concurrent with this final rule, an interim final rule to align risk corridors calculations with the single risk pool requirement. Under that interim final rule (78 FR 15541 – 15552) an issuer could reasonably allocate, in accordance with §153.520, allowable administrative costs across its businesses pro rata by premiums earned, leading to an issuer-level risk corridors calculation for its QHP business. CMS seeks comments on this provision in the interim final rule, and comments are due no later than April 30, 2013.

3. Risk Corridors Data Requirements (§153.530)

CMS finalizes data requirements (in the absence of any comments) that:

- A QHP issuer must submit data to HHS on premiums earned, including premium tax credits;
- A QHP issuer must submit data to HHS on the allowable costs.
 - Risk adjustment and reinsurance payments are regarded as after-the-fact adjustments to allowable costs for purposes of determining risk corridor amounts;
 - Allowable costs are to be reduced by the amount of any cost-sharing reductions received from HHS to the extent it is not paid to a provider furnishing the item or service. (See §156.430 below for the cost-sharing standards to which this is linked).

| CMS Example | |
|--|--------------|
| Assume QHP with following experience: | |
| Incurred allowable costs for benefit year | \$200 |
| Risk Adjustment payment received | \$25 |
| Reinsurance payment received | \$35 |
| Cost-sharing reduction payment received | \$15 |
| Allowable costs: (\$200 - \$25 - \$35 - \$15 = \$125) | \$125 |

CMS also finalizes changes in the rules under which it will address the manner of submitting required risk corridor data in future guidance, rather than in this notice of benefit and payment parameters.

E. Provisions for the Advance Payments of the Premium Tax Credit and Cost-Sharing Reduction Programs

1. Exchange Responsibilities with Respect to Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions

a. Special Rule for Family Policies (§155.305(g)(3))

Current §155.305(g)(3) sets out policy for determining eligibility for cost-sharing reductions for individuals in different tax households but enrolled in the same family QHP policy. It sets out a hierarchy under which the lowest level of cost sharing subsidy that any one individual in the family QHP policy is eligible for would apply to the combined household QHP. For example, if one family member is in a taxable household with income of 140% of the FPL which would qualify for a silver plan AV of 94%, and another is in a taxable household with income of 160% of the FPL, which would qualify for a silver plan variation with AV of 87%, the lower 87% AV level would be the applicable cost-sharing subsidy for the family in the QHP in the Exchange.

CMS finalizes its proposal to add to the hierarchy to deal with the situation where one individual is not eligible for any AV subsidy (member of a taxable household with income above 250% of the FPL), in which case the family in the QHP would be eligible for no AV subsidy to the silver policy as this would be the lowest applicable level of cost sharing. In addition, CMS finalizes its proposal to add in to the hierarchy the special determinations for Indians and non-Indians enrolled in a family policy (see §155.300).

CMS notes that current §155.305(g)(3) and this change may limit cost-sharing reductions that members of a family might receive, but that §1402 of the ACA precludes any individual from receiving benefits for which the individual is ineligible. CMS notes in response to comments the difficulty of applying different AVs, deductibles and copayments and OOP limits within the same family policy. It further notes that nothing precludes qualified individuals from enrolling in separate policies rather than one family policy in order to secure the highest cost-sharing subsidy for which each individual is eligible, and that it will encourage Exchanges to provide guidance to consumers so that families can best take advantage of cost-sharing reductions.

b. Recalculation of Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions (§155.330(g))

Current §155.330 sets out Exchange standards for redetermination of eligibility during a benefit year, including requirements for individuals to report changes, verification processes, periodic examination of data sources by Exchanges to identify potential changes, and redetermination and notification standards.

Redetermination of Advance Payment of Premium Tax Credits: CMS notes that, under the Internal Revenue Code (IRC) rules for premium tax credits at 26 CFR 1.36B-4(a)(1), it is important when calculating advance payments that the Exchange act to minimize any potential discrepancies between the advance payments and the final premium tax credit amount, which is reconciled to actual income on the filer's end-of-year tax return.

CMS finalizes new §155.330(g)(1) to clarify how eligibility redeterminations affect eligibility for advance payments of the premium tax credit. When making such a recalculation during the year, the Exchange must account for any advance payments already made during the year, so that the recalculated advance payment is projected to result in total advance payments that correspond to the tax filer's projected premium tax credit for the benefit year. CMS provided the following example in the proposed rule:

- At the beginning of 2014, a tax filer is determined to be eligible for a tax credit of \$35 per month (\$420 for the year), based on expected income and QHP rating in the area, and an advance payment of the premium tax credit of that monthly amount is made to the QHP.
- In June, the tax filer reports and the Exchange verifies a reduction in expected household income for the year, and the Exchange determines that the filer would be eligible for a tax credit of \$1,356 for the year which would be \$113 per month if spread over the 12 months.
- In determining the advance payment for the remaining 6 months of the year, CMS would first determine the total amount already paid ($\$35 * 6 = \210) and subtract it from the \$1,356 amount that is the new projected tax credit for the year ($\$1,356 - \$210 = \$1,146$).
- It then divides that amount by the remaining 6 months to determine the advance payment due for each of the final six months of the year ($\$1,146 / 6 = \191).

The advance payment after such a redetermination must be greater than or equal to zero. That means that in the case of a redetermination based on an increase in income, the advance payment could decrease for the remainder of the year, but any recovery of a net overpayment over the course of the year would be reconciled on the filer's tax return for the year.

CMS does not include in the final rule an option it considered, which was to make retroactive payments to the QHP issuer in the case of a reduction in income, instead of making the full adjustment over the remaining months of the benefit year.

Redetermination of Cost-sharing Reductions: CMS finalizes a new §155.330(g)(2) to clarify how eligibility redeterminations affect eligibility for cost-sharing reductions. The Exchange must determine an individual eligible for the category of cost-sharing reductions that corresponds to his or her expected household income for the benefit year.

Unlike premium tax credits, cost-sharing reductions are not reconciled at the end of the year. As a result, redeterminations of eligibility during a year should not take into account cost-sharing reductions already provided during the year. CMS provides an example in the case of a redetermination of eligibility. The tax filer is reassigned (within the silver plan) to the AV subsidy level to which they are newly eligible (either a higher or lower AV level) based on their expected annual income, and deductible limits, copayments and maximum OOP limits would be determined under the new AV structure of that plan for the remainder of the year (taking into account previous deductible and cost-sharing payments made by the individual during the benefit year). CMS provides additional detail at §156.425 (below).

CMS notes, in response to comments, that it expects that QHP issuers will provide guidance to enrollees about the importance of reporting changes during the year and the avenues through which changes can be reported. CMS does not specify that the Exchange will consider the

statutory limits on repayment of advance payment premium tax credits, as these limits are separate from the premium tax credit calculation itself.

c. Administration of Advance Payment of the Premium Tax Credit and Cost-Sharing Reductions (§155.340)

Current §155.340 sets out information reporting requirements for Exchanges for administration of the advance payment premium tax credits and cost-sharing reductions.

CMS finalizes two new paragraphs to deal with situations in which individuals in a tax filer's household who are eligible for advance payment of a premium tax credit are enrolled in more than one QHP or stand-alone dental plan. New §155.340(e) sets final policy for Exchanges, and, in response to comments, provides additional flexibility than included in the proposed rule. New §155.340(f) sets out the policy for dealing with those situations in the FFEs.

§155.340(e) sets out final policy for the Exchanges.

- The Exchange must first allocate the portion of the advance payment tax credit that is less than or equal to the aggregate adjusted monthly premiums for the QHP policies properly allocated to the EHB among QHPs in a reasonable and consistent manner specified by the Exchange. This provides more flexibility than the proposed rule, which proposed that such amounts would be allocated in proportion to the respective portions of the premiums for those QHP policies properly allocated to EHB.
- The Exchange must allocate any remaining advance payment premium tax credit to the stand-alone dental policies, if any, in a reasonable and consistent manner specified by the Exchange. This too provides more flexibility than the proposed rule, which would have allocated such amounts in proportion to the respective portions of the adjusted monthly premiums for the stand-alone dental policies properly allocated to the pediatric dental benefit.

CMS adopts the final policy with new flexibility for Exchanges in response to comments that the proposed methodology was too complicated for consumers to understand and that it would have delayed calculation of the allocation of premium tax credits until after QHPs have been selected. CMS notes, in making the change, the importance of transparency and a consumer-friendly shopping experience. The final policy provides Exchanges the flexibility to opt, for example, for a per member approach of the type set out for the FFE (below).

§155.340(f) sets out final policy for how the FFE will implement this provision.

- The Exchange will first allocate the advance payment premium tax credit among QHPs based on the number of enrollees covered under the QHP, weighted by the age of the enrollees using the default uniform age rating curve established by the Market Reform Rule at §147.102(e). The portion allocated to any single QHP policy is not to exceed the portion of the QHP's adjusted monthly premium properly allocated to EHB; if it exceeds that amount, any excess is reallocated evenly among all other QHPs in which individuals are enrolled.
- The Exchange will allocate any remaining advance payment premium tax credit among stand-alone dental policies based on the number of enrollees covered under the stand-

alone dental policy, weighted by the age of the enrollees using the default uniform age rating curve established by the Market Reform Rule. The portion allocated to any single stand-alone dental policy is not to exceed the portion of the policy's monthly premium properly allocated to EHB; if it exceeds that amount, any excess is reallocated evenly among all other stand-alone dental policies in which individuals are enrolled.

CMS provides a detailed example of the allocation for a family in an FFE.

CMS finalizes at paragraph §155.340(g) its proposal (originally at §155.340(f)) its standards for an Exchange when it is facilitating the collection and payment of premiums to QHP issuers. In that situation the Exchange must:

- Reduce the portion of the premium collected from the enrollee by the amount of the advance payment premium tax credit; and
- Display in each billing statement for the enrollee the amount of the advance payment premium tax credit, and the remaining premium owed for the policy.

CMS notes that this is equivalent to the proposed §156.460(b) requirement for QHP issuers when the issuer submits the billing statement to the enrollee, and is designed to ensure that an enrollee is aware of both the total cost of the premium and the amount of the advance payment premium tax credit.

2. Exchange Functions: Certification of Qualified Health Plans

Current Subpart K of Part 155 sets out the standards for Exchange Functions for Certification of Qualified Health Plans.

CMS finalizes, with only technical changes, a new §155.1030 to include certification standards related to advance payments of the premium tax credit and cost-sharing reductions. CMS also finalizes at §156.470 (see below) related standards for issuers with changes in response to comments.

An Exchange must ensure under §155.1030(a) that each issuer submit the required plan variations in AV and cost-sharing set out in proposed §156.420, certify that the variations meet those requirements, and report the AVs of the QHPs and silver plan variations to HHS. CMS expects an Exchange to collect information necessary, including cost-sharing requirements for the plan variations, such as the annual limitation on cost-sharing and any reductions in deductibles, copayments or coinsurance. The Exchange will also collect or calculate the AV of each QHP and silver plan variation.

An Exchange must collect under §155.1030(b) and review annually the information that an issuer must submit under proposed §156.470 that would allow for the calculation of premium tax credits and cost-sharing reductions. CMS expects that the Exchange will review the information in conjunction with the rate and benefit information submitted by an issuer under §156.210, and notes that it proposed revisions to the reporting requirements for the Effective Rate Review Program in the Market Reform rule to include rate allocation and expected claims cost allocation information from issuers of metal level health plans. CMS expects that the alignment between the provisions can streamline reporting by issuers and review by the Exchange. CMS notes that

it is the Exchange's responsibility to ensure that each issuer performs the allocations appropriately, including those that are not reported as part of the Effective Rate Review Program.

CMS notes that the information would be used by the Exchange to calculate the dollar amounts of the advance payments of premium tax credits and cost-sharing reductions as described in §156.430.

An Exchange must submit to HHS the approved allocations for each health plan at any level of coverage, or stand-alone dental plan, offered or proposed to be offered in the individual market in the Exchange. An Exchange must collect annually any estimates and supporting documentation from a QHP issuer to receive advance payments of the value of cost-sharing reductions under §156.430(a), and submit the estimates and supporting documentation to HHS.

CMS adds in the final rule, in response to comments, a new §155.1030(c) to clarify that the Office of Personnel Management is responsible for ensuring that Multi-State plans comply with the Exchange standards.

In §156.470, CMS finalizes related requirements on issuers. Issuers must provide its allocations to EHB and any other health benefits. Stand-alone dental plans must provide the dollar allocation to the pediatric dental essential health benefit and any other benefits offered by the plan. CMS sets allocation standards for QHPs and for stand-alone dental plans and requires disclosure of attribution and allocation methods.

CMS adds in the final rule, in response to comments, a new paragraph §156.470(f) to clarify that issuers of Multi-State plans must submit this required information to the Office of Personnel Management (similar to the new §155.1030(c) noted above).

CMS also notes, in response to comments:

- It has streamlined actuarial reporting requirements in the Market Reform Rule, and suggests that Exchanges use similar reporting processes.
- It refers readers to the Essential Health Benefits final rule for guidance on the prescription drug essential health benefits.
- It clarifies that stand-alone dental plans are not required to follow the rating standards set forth in the final Market Reform Rule.
- It does not include in the final rule several proposed specific allocation standards for stand-alone dental plans. CMS believes that the allocation standard finalized is sufficient, which is that the allocation be performed by a member of the American Academy of Actuaries in accordance with generally accepted actuarial principles and methodologies. CMS intends to provide further guidance on the reporting processes for stand-alone dental plans in the FFE.

Information Collection Requirements

CMS, in its review of Information Collection Requirements, sets out the following estimates for new §155.1030 QHP certification standards related to advance payments of the premium tax credit and cost-sharing reductions. It estimates:

- An incremental cost of approximately \$181/year for each partnership or State Exchange to collect, validate and submit to HHS required information on required plan variations, for a total costs of \$9,240 for 51 Exchanges.
- An incremental cost of approximately \$19 per year for Exchange collection and submission of required information for stand-alone dental plans, with an assumption of 20 stand-alone dental plans, for a total cost of \$385.
- An incremental cost of approximately \$3.21 for Exchanges to collect and submit required documentation for advance payment of certain cost-sharing reductions, for a total cost of \$164.

3. QHP Minimum Certification Standards Relating to Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions

Current Part 156 sets out Health Insurance Issuer Standards Under the ACA, Including Standards Related to Exchanges. CMS finalizes a new subpart E – Health Insurance Issuer Responsibilities with Respect to Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions, to clarify that meeting these standards is a requirement of QHP certification. Failure to comply will result in decertification of the QHP and other enforcement actions.

a. Definitions (§156.400)

CMS finalizes definitions that would apply only to subpart E, with one technical change noted below. CMS notes that some cross-reference definitions elsewhere in parts 155 and 156.

- “Standard plan” is a QHP offered at one of the four “metals” levels of coverage, with an annual limit on cost-sharing that conforms to §156.130(a). Standard plans are referred to as standard bronze, standard silver, standard, gold, and standard platinum plans.
- “Silver plan variation” is with respect to a standard silver plan, any of the variations of that plan described in proposed §156.420(a) (which are the income-related reductions in annual limits, and reductions in cost-sharing associated with income-related increases in AV).
- “Zero cost-sharing variation” is, with respect to a QHP at any level of coverage, the variation of the QHP that provides for the elimination of cost-sharing for Indians based on household income level under proposed §156.420(b)(1).
- “Limited cost-sharing variation” is, with respect to a QHP at any level of coverage, the variation of the QHP that provides for the elimination of cost-sharing for the receipt of benefits from the Indian Health Service and certain other providers, irrespective of income levels.
- “Plan variation” is a zero cost-sharing, limited cost sharing, or silver plan variation. CMS reiterates that the plan variations of a QHP are not separate plans, but variations in how the cost-sharing required under the QHP is to be shared between the enrollee and the Federal government.
- “De minimus variation for a silver plan variation” means a single percentage point variation in AV (CMS corrects a cross reference in the final rule). This differs from the 2 percentage point variation for the standard plans in the EHB/AV rule. CMS notes in response to comments that the cost-sharing reductions are reimbursed by the federal

government, so the degree of flexibility afforded to issuers for silver plan variations should be somewhat less. CMS seeks to balance the need to ensure that individuals receive full value of the cost-sharing reductions for which they are eligible with issuers' ability to set reasonable cost-sharing.

- “Annual limitation on cost-sharing” means the annual dollar limit on cost sharing required to be paid by an enrollee that is established by a particular QHP. CMS notes that under the EHB/AV rule, the annual limit would not include cost-sharing for benefits provided outside of a QHP’s network, and if a state requires benefits in addition to EHB, the provisions related to cost-sharing reductions do not apply to those additional benefits. In the final rule, CMS clarifies, in response to comments, that in developing silver plan variations, issuers have the flexibility to reduce cost sharing only for in-network services so long as the required AV levels are achieved.
- “Maximum annual limitation on cost-sharing” means the uniform maximum that would apply to all QHPs for a particular year.
- “Reduced maximum annual limitation on cost-sharing” is the dollar value of the maximum annual limitation on cost-sharing for a silver plan variation after applying the reduction in the maximum annual limitation for each silver plan variation. CMS notes again that annual limitation applies only for cost-sharing with respect to EHB, and does not apply to cost-sharing for out-of-network services.

b. Cost-sharing Reductions for Enrollees (§156.410)

CMS finalizes in §156.140(a) that a QHP must ensure that an individual eligible for cost-sharing reduction and assigned to a particular plan variation pay only the required cost sharing for the applicable covered service for that plan variation. The cost-sharing reduction must be applied when the cost-sharing is collected. An issuer may not create a system in which an individual pays the full cost-sharing (for example, for the standard silver plan) and then apply for a refund to reflect the cost-sharing reduction for the applicable plan variation. Further, the issuer must ensure that the enrollee is not charged any type of cost-sharing after the applicable annual limitation on cost-sharing has been met. An individual is not eligible for cost-sharing reductions until any applicable (and potentially reduced) deductible is met.

CMS finalizes in §156.140(b) a process by which a QHP issuer assigns a qualified individual to the applicable plan variation.

- If the individual is eligible for cost-sharing reductions, the QHP issuer must assign the individual to the silver plan variation of the selected silver plan based on the individual’s income-based eligibility under §156.420. CMS noted in the proposed rule that it chose not to allow the individual to opt out of the most generous silver plan for which the individual is eligible, because it would cause confusion without policy benefit. Further, CMS notes that an individual may choose not to apply for cost-sharing reductions. CMS, in response to comments, encourages Exchanges to only display the variation of each QHP plan for which the consumer is eligible.
- If the individual is eligible for cost-sharing reductions for Indians with lower house income (under proposed §155.350), the QHP issuer must assign the individual to the zero cost-sharing plan variation of the selected QHP.

- If the individual is eligible for cost-sharing reductions for Indians regardless of household income and chooses to enroll in a QHP, the QHP issuer must assign the individual to the limited cost-sharing plan variation of the selected QHP with no cost-sharing for benefits received from the Indian Health Service and certain other providers.
- If the individual is not eligible for cost-sharing reductions and chooses to enroll in a QHP, the QHP issuer must assign the individual to the selected QHP with no cost-sharing reduction.

c. Plan Variations (§156.420)

CMS finalizes regulatory language on plan variations and provides an extensive discussion of its implementation for the 2014 benefit year.

§156.420(a) provides an annual process by which QHP issuers submit for certification, prior to each benefit year, for the standard silver plan and each silver plan variation for which individuals are eligible on the basis of income:

- The reduced annual limitation on cost sharing for that silver plan variation complying with the limits set by HHS in the annual notice of benefit and payment parameters;
- Other cost-sharing reductions such that the AV of the silver plan variation reaches the required AV levels of 94, 87 and 73 percent (for the appropriate income tier).

§156.420(b) establishes a comparable process for QHP issuers to submit for certification prior to each benefit year the zero cost-sharing and limited cost-sharing plans for which Indians are eligible.

§156.420(c) provides that a standard silver plan and each silver plan variation must cover the same benefits and providers and require the same out-of-pocket spending for benefits other than EHB. §156.420(d) establishes comparable requirements for zero cost-sharing and limited cost-sharing plans, and CMS notes that issuers must meet all other QHP requirements in these plan variations.

§156.420(e) requires that cost-sharing under any silver plan variation for an EHB may not exceed the corresponding cost-sharing required under the standard silver plan or a silver plan variation with a lower AV.

§156.420(f) provides that, notwithstanding the de minimus variation standards, the minimum AV difference between the standard silver plan and the silver plan for those with income between 200 and 250 percent of the FPL (AV of 73%) cannot be less than 2 percentage points.

CMS includes in the final rule, in response to comments, a new paragraph (g) to clarify that OPM will determine the time and manner for Multi-State plans to submit plan variations.

CMS finalizes its approach for 2014 in this annual notice. CMS notes that the law first directs issuers to reduce the maximum annual limit on cost-sharing, and then adjust cost-sharing to reach the required AV. However, the Secretary may adjust the reduction in the annual limit if

necessary to ensure that it is possible to achieve the required AV with other cost-sharing provisions.

CMS finalizes for 2014 its proposal not to reduce the maximum annual limit on cost-sharing for those with income between 250 and 400 percent of the FPL, because such a reduction would require a significant increase in deductibles and copayments in order to retain the AV at 70 percent in the standard silver plan.

For those with household income of 100-250 percent of the FPL, CMS finalizes its policy based on the annual three-step process for design of silver plan variations.

Step 1: First, CMS identifies in this annual HHS notice of benefit and payment parameters the maximum annual limitation on cost-sharing applicable to all plans.

The statutory maximum annual limit on cost-sharing for 2014 is the dollar limit on cost-sharing for high deductible health plans that will be set by the IRS for 2014. The IRS will not publish this amount until the spring of 2013, so CMS proceeds with a methodology replicating the IRS methodology, and using projected CPI data from the Office of Management and Budget. CMS estimates that the maximum OOP limit will be \$6,400 for self-only coverage and \$12,800 (double that amount) for other than self-only coverage. CMS notes that issuers may rely on this calculation even if the IRS issues a different amount in the future.

Step 2: CMS analyzes the effect on AV of the reductions in the maximum annual limits on cost sharing for those eligible for reduced cost-sharing (see table below.) CMS adjusts the limits on cost-sharing, if necessary, to ensure that the AV would not exceed the AV set under the law. CMS proceeds with that analysis for benefit year 2014.

CMS developed three model standard silver QHP cost-sharing packages, described in the proposed rule, that included the proposed \$6,400/\$12,800 annual limits:

- PPO: \$1,675 deductible, 20% in-network coinsurance, \$6,400/\$12,800 annual limit.
- PPO: \$575 deductible, 40% in-network coinsurance, \$6,400/\$12,800 annual limit.
- HMO: \$2,100 deductible, 20% coinsurance, several special deductible and copay provisions, \$6,400/\$12,800 annual limit.

CMS then observed how the required reduction in the maximum annual limit would affect the AV of silver plan variations with those cost-sharing packages:

- For those with income between 100-150 percent of FPL, the required 2/3 reduction did not cause AV to exceed the 94 percent statutory level.
- For those with income between 150-200 percent of FPL, the required 2/3 reduction did not cause AV to exceed the 87 percent statutory level.
- However, for those with income between 200-250 percent of FPL, the required 1/2 statutory reduction did cause the AV of the modeled plans to exceed the statutory AV of 73 percent.

Based on this analysis, CMS finalizes that for 2014, the maximum annual limit for those with income between 200-250% of the FPL would be reduced by about 1/5, rather than 1/2, and further moderates the reductions for all three income categories to account for any potential inaccuracies. When combined with the policy to not reduce the maximum OOP limit for those with income between 250-400 percent of the FPL, CMS finalizes the following maximum allowable limitations on cost-sharing for 2014. The table below presents both the statutory standard and the CMS final policy for 2014 adjustment.

| CMS' Maximum Annual Limits on Cost-Sharing for 2014 | | | |
|--|-----------------|----------------------------|--|
| | AV Level | Statutory reduction | CMS proposed annual limit for self only/non-self only and estimated reduction |
| Standard silver plan | 70% | | \$6,400/\$12,800 |
| Household Income | | | |
| 100-150% of FPL | 94% | 2/3 reduction | \$2,250/\$4,500 (65% reduction) |
| 150-200% of FPL | 87% | 2/3 reduction | \$2,250/\$4,500 (65% reduction) |
| 200-250% of FPL | 73% | 1/2 reduction | \$5,200/\$10,400 (19% reduction) |
| 250-300% of FPL | 70% | 1/2 reduction | \$6,400/\$12,800 (no reduction) |
| 300-400% of FPL | 70% | 1/3 reduction | \$6,400/\$12,800 (no reduction) |

Step 3: QHP issuers must develop three variations of its standard silver plan (reflecting the income-related tiers with AVs of 94 percent, 87 percent, and 73 percent), with the annual limits noted above, for each of the silver plans that they offer in the Exchange. If the reduced annual limit on cost-sharing results in a change in the AV of the plan by more than the required de minimus amount of 1 percentage point, the QHP issuer must adjust the cost-sharing (not the proposed annual limits) to reach the desired AV level.

CMS notes, in response to comments, several clarifications:

- If a health plan's design for plan variation is not compatible with the AV calculator, the issuer is required to follow the processes specified in the EHB/AV final rule.
- CMS will provide further guidance on how silver plan variations could be designed to be compatible with HSAs.
- CMS intends to work with states that are interested in further supplementing the cost-sharing reductions to assess how such reductions would interact with the requirements regarding plan variations.
- An issuer must submit the required three plan variations for each of the silver plans that an issuer offers in the Exchange.
- Issuers may not switch between copayments and coinsurance for silver plan variations for the same benefit; but nothing limits an issuer's ability to appropriately use reasonable medical management techniques consistently in its silver plan variations.

Information Collection Requirements

CMS, in its review of Information Collection Requirements, sets out the following estimates for new §156.420, plan variations. It estimates:

- 1,200 issuers will participate in an Exchange nationally;
- Each issuer will offer one QHP per metal level, with four zero cost-sharing variations and four limited cost-sharing variations (one per metal level) and three variations of the standard silver plan for low-income populations, for a total of four standard plans and 11 plan variations.
- CMS estimates it would cost an issuer \$866 to submit the information on plan variations, for total cost for 1,200 issuers of \$1,039,698.

d. Changes in Eligibility for Cost-Sharing Reductions (\$156,425)

CMS finalizes its proposal that if an Exchange notifies a QHP issuer of a change in eligibility for cost-sharing reductions, then the QHP issuer must change the individual's assignment so that the individual is assigned to the applicable standard plan or plan variation in accordance with the Exchange effective date of eligibility.

In the case of a change in assignment to a different standard plan or plan variation in the course of a benefit year, the QHP issuer must ensure that any deductible and cost sharing paid under the previous plan variation or standard plan is accounted for in the calculation of the deductibles and annual limits in the new plan variation for the remainder of the benefit year. A change from or to an individual or family policy of a QHP during a year does not constitute a change in plan, so individuals would not be penalized by changes in eligibility for cost-sharing reductions during the benefit year or the addition or removal of family members. They would not be eligible for any refund on cost-sharing to the extent that a newly applied deductible or annual limitation on cost-sharing is exceeded by prior cost-sharing. A QHP issuer is not prohibited from or required to extend this policy to situations in which the individual changes QHPs, including enrollment at a different metal level, but would be permitted to extend the policy provided it is applied across all enrollees in a uniform manner.

CMS provides, in response to comments, examples for individuals switching to plan variants with higher or lower deductibles.

Switch to plan with higher deductible:

- Individual in plan variation with \$500 deductible and satisfies the \$500 deductible, and pays \$100 in copayments;
- Individual switches to plan variation with \$750 deductible;
- The plan would apply the $\$500 + \$100 = \$600$ toward the new deductible, and individual would have to satisfy the remaining \$150 of the new deductible.

Switch to plan with lower deductible:

- Individual in plan variation with \$900 deductible, and satisfies that deductible;
- Individual switches to plan variation with \$750 deductible;
- Individual does not receive a rebate of the \$150 previously paid, but that \$150 in spending does count toward the annual limit on cost sharing in the new plan variation.

e. Payment for Cost-Sharing Reductions (§156.430)

CMS reviews the statutory authorities for payment to QHP issuers to pay for the cost-sharing reductions, and finalizes a payment approach under which it would make monthly advance payments to issuers to cover projected cost-sharing reduction amounts and reconcile those advance payments at the end of the benefit year to the actual cost-sharing reduction amounts. CMS noted in the proposed rule that this is similar to the process employed for the low-income subsidy under Medicare Part D.

CMS finalizes in §156.430(a), with changes noted, that for each health plan that an issuer offers or intends to offer in the individual market in an Exchange, the issuer must provide the Exchange annually, prior to the benefit year, for approval by HHS, an estimate of the dollar value of the cost-sharing reductions to be provided over the benefit year.

- If the QHP is a silver plan, it must include the per member per month (PM/PM) dollar value of the cost-sharing reductions under each silver plan variation.
- All QHPs must provide the PM/PM dollar value of cost-sharing reductions under the zero cost sharing plan variation.
- If an issuer seeks advance payments for the limited cost-sharing plan, it must provide the PM/PM dollar value of cost-sharing reductions under that plan.
- All submissions must be developed using the methodology specified by HHS in the annual HHS notice of benefit and payment parameters, and must be accompanied by supporting documentation.
- HHS' approval is based on whether the estimate is made consistent with HHS' methodology.

CMS adds a new paragraph in the final rule clarifying that issuers of Multi-State plans must provide the estimates to OPM at a time and manner established by OPM.

CMS finalizes for 2014 a simplified methodology for estimating the value of the cost-sharing reductions. CMS believes that a lack of data will make it difficult to accurately predict the value of the cost-sharing reductions, even if a complex methodology is used, and it intends to review the methodology in future years, once more data are available. CMS also notes that the payment reconciliation process described in §156.430(c) through (e) below ensure that a QHP issuer is made whole for the value of cost-sharing reductions during the year, which may not be equal to the advance payments.

CMS finalizes its proposal that for 2014, advance payments for cost-sharing reductions for silver plan variations be computed as follows:

Monthly PMPM advance payment =

Monthly expected allowed claims for the standard silver plan (AV 70%),
multiplied by
An induced utilization factor for the increased use at a higher AV (see table
below)

multiplied by
The difference between the silver plan variation AV and the standard silver plan AV.

The induced utilization factors are presented in Table 23 in the final rule (78 FR 15487).

| From Table 23: Induced Utilization Factors for Computing Cost-Sharing Reduction Advance Payments | | |
|---|-----------------------|-----------------------------------|
| Household income | Silver Plan AV | Induced utilization factor |
| 100-150% of FPL | Plan variation 94% | 1.12 |
| 150-200% of FPL | Plan variation 87% | 1.12 |
| 200-250% of FPL | Plan variation 73% | 1.00 |

Health Policy Alternatives provides the following example of how the calculation appears to work. The example starts with several assumptions:

- A silver plan QHP with an actual AV of 70%, and PM/PM expected allowed claims costs of \$500.
- Silver plan variations with an actual AV of 94%, 86% (within the de minimus 1% variation from 87%) and 73%.

The assumptions and calculations are presented in the table below.

| HPA Example of Calculation of Advance Payment to a particular QHP for Cost-Sharing subsidies | | | | |
|---|-----------------------------|-------------------------------|------------------------|------------------------|
| Calculation | Standard Silver Plan | Silver Plan Variations | | |
| | | 100-150% of FPL | 150-200% of FPL | 200-250% of FPL |
| 1. Actual AV* (assumption) | 70% | 94% | 86%* | 73% |
| 2. PM/PM expected allowed claims costs (assumption) | \$500 | | | |
| 3. Induced utilization factor (rule) | | 1.12 | 1.12 | 1.00 |
| 4. PM/PM expected: allowed claims * induced utilization (2 * 3) | | \$560 | \$560 | \$500 |
| 5. Difference between AV of standard silver plan and AV of silver plan variation (differences in columns on line 1 from the 70% standard silver AV) | | 24% | 16% | 3% |
| 6. Advanced payment PM/PM to the QHP for cost-sharing subsidy: expected PM/PM * the AV difference (5 * 4) | | \$134.40 | \$89.60 | \$15.00 |
| * Note: the AV for this calculation is the actual approved AV of the particular plan, which can differ from the statutory target. For example, the silver plan variation in this example for those with income between 150-200% of the FPL has an AV of 86%, which is within the +/-1% de minimus variation from the statutory target of 87%. | | | | |

CMS finalizes a similar process for advanced payment of cost-sharing reductions for zero cost sharing plans for Indians (see below). QHP issuers have the option to forego submitting an estimate for advance payment for the limited cost-sharing plan variation for Indians if they believe the operational cost of developing the estimate is not worth the value of the advance payment. If the issuer does seek advance payments, it must submit an estimate meeting standards set out in HHS' annual notice of benefit and payment parameters. For 2014, CMS issuers must submit a reasonable estimate for the limited cost-sharing plan variation developed by a member of the American Academy of Actuaries.

CMS finalizes in §156.430(b), with changes, its proposal to make periodic advance payments to issuers based on the approved advance estimates, determined above, and confirmed enrollment information. In response to comments, CMS adds in the final rule new language authorizing the Secretary to adjust the advance payment for a particular QHP during the year if the issuer provides evidence, certified by a member of the American Academy of Actuaries, that the advance payments for a particular QHP are likely to be substantially different than the actual cost-sharing reduction amounts that the QHP provides and will be reimbursed by HHS. CMS does not include a formal process for submission of information as it believes that the need will be rare and likely unique to particular QHPs.

CMS finalizes in §156.430(c), with changes, that QHP issuers report to HHS the actual amount of cost-sharing reductions provided. CMS clarifies and simplifies the language so that in the case of payment for EHB paid on any basis, in whole or in part on a fee-for-service basis, or on another basis (such as per member per month payments to providers), the issuer report total allowed costs for EHB, broken down by what the issuer paid, what the enrollee paid, and the amount the enrollee would have paid under the standard plan without cost-sharing reductions. CMS further clarifies that allowed costs that an enrollee would have paid under the standard plan be included only to the extent the amount was actually payable or reimbursed by the QHP. CMS clarifies that the amount reported as paid by the enrollee should include any cost sharing paid by a third party, including a state, on behalf of an enrollee.

As it did in the proposed rule, CMS notes that it expects that issuers and providers in non-fee-for-service arrangements, such as capitated models, would make available for providers compensation for cost-sharing through their negotiated capitation payments.

Further, in response to comments, CMS establishes in new paragraphs (c)(3) and (4), through an interim final rule published on the same day (78 FR 15541 – 15552), a simplified methodology for calculating the amounts that would have been paid under the standard plan without cost sharing reductions. A QHP issuer may use a formula based on certain summary cost-sharing parameters of the standard plan. CMS sets out the detailed methodology in that interim final rule and seeks comments. Comments are due no later than April 30, 2013.

CMS finalizes in §156.430(d) its proposal to periodically reconcile advance payments against actual cost-sharing reduction amounts reported under (c) above.

CMS finalizes in §156.430(e) that if the advance payments are higher (or lower) than the actual cost-sharing amounts, the issuer (or HHS) would be responsible for reimbursement of the other party.

CMS finalizes in §156.430(f) that a QHP issuer remains eligible for payment of cost-sharing reductions provided prior to termination of coverage, including during any grace period for non-payment of premiums. A QHP issuer would be required to repay any advance payments made with respect to any month after any termination of coverage effective date. CMS proposes that if any other retroactive termination, or late determination of the termination, is the fault of the QHP issuer, as reasonably determined by the Exchange, the issuer would not be eligible for advance payments and reimbursements of cost-sharing reductions provided during the period following the termination of coverage effective date. If the termination, or late determination of the termination, is not the fault of the QHP issuer, as reasonably determined by the Exchange, the QHP issuer would be eligible for advance payments and reimbursement of cost-sharing reductions during such a period. A QHP issuer is eligible for advance payments and reimbursement for cost-sharing reductions provided during any period of coverage pending resolution of inconsistencies in information required to determine eligibility under §155.315(f).

Information Collection Requirements

CMS, in its review of Information Collection Requirements, sets out the following estimates for new §156.430. It estimates:

- A total of 1,200 issuers.
- A cost of approximately \$48 for an issuer to submit a response for each of the plan variations.
- Four submissions per issuer, for a total cost for the 1,200 issuers of \$228,912.

f. Plans Eligible for Advance Payments of the Premium Tax Credit and Cost-sharing Reduction (§156.440)

CMS finalizes (with technical changes to correct cross-references) its proposal that the provisions of subpart E apply to QHPs offered in the individual market in the Exchange. They do not apply to catastrophic plans described in §156.155 (to conform with previous definitions and policies) and the provisions for cost-sharing reductions do not apply to stand-alone dental plans, as that would entail significant operational complexities. The provisions related to advance payment of premium tax credits do apply to stand-alone dental plans. The provisions apply to child-only plans.

g. Reduction of an Enrollee's Share of Premium to Account for Advance Payments of the Premium Tax Credit (§156.460)

CMS finalizes its proposal that a QHP issuer that receives notice from the Exchange of an individual's eligibility for an advance payment premium tax credit must:

- Reduce the portion of the premium charged the individual for the applicable months by the amount of the advance payment premium tax credit;

- Notify the Exchange of the reduction as part of its standard acknowledgment (that information will in turn be submitted to the Secretary via enrollment information); and
- Include in each billing statement the amount of the advance payment of the premium tax credit for the applicable month and the remaining premium owed.

An issuer may not refuse to commence coverage or terminate coverage on account of any delay in the advance payment of a premium tax credit if the issuer has been notified by an Exchange that it will receive such a payment. CMS expects that advance payments will be paid in the middle of the month.

Information Collection Requirements

CMS, in its review of Information Collection Requirements, sets out the following estimates for new §156.460, reduction of an enrollee's share of premium to account for advance payment of the premium tax credit. It estimates:

- A total of 1,200 issuers.
- An incremental cost of \$3.30 for each issuer to notify the Exchange (as part of standard enrollment acknowledgment).
- A total cost for the 1,200 issuers of \$3,849.

h. Allocation of Rates and Claims Costs for Advance Payments of Cost-Sharing Reductions and the Premium Tax Credit (§156.470)

CMS finalizes at §156.470, with modification, its proposal that issuers provide to the Exchange annually for approval for each metal level health plan and stand-alone dental plan, an allocation of the rate and expected allowed claims costs for the plan, in each case to: EHB (other than abortion services for which federal funding is precluded) and to any other services or benefits offered by the health plan. In the case of a stand-alone dental plan, the issuer must report the allocation to the pediatric dental EHB for an individual under the age of 19 and to any other benefits that are not the pediatric dental EHB. These provisions, and the modification, are related to the previously reviewed Exchange requirements at §155.1030 and are discussed in the summary of that section.

Information Collection Requirements

CMS, in its review of Information Collection Requirements, sets out the following estimates for new §156.470, allocation of rates and claims costs for advance payments of the premium tax credit and cost-sharing reductions. It estimates:

- No burden on the issuers that submit their rates through the Effective Rate Review Program.
- An estimated cost of about \$230 for each of an estimated 20 stand-alone dental plans, for a total cost of \$4,585.

i. Special Cost-Sharing Reduction Rules for Indians

General: CMS reviews in detail a number of provisions throughout subpart E implementing section 1402 of the ACA, which governs cost-sharing for Indians.

Section 1402(d)(2) directs a QHP issuer to treat an Indian with household income of not more than 300 percent of the FPL as an “eligible insured” and to eliminate all cost-sharing. CMS interprets this definition to include only months in which the individual is eligible for premium tax credits in the Exchange.

Section 1402(d)(2) prohibits cost-sharing under a QHP for items and services provided directly by the IHS, an Indian Tribe, Tribal Organization, Urban Indian Organization or through referral under contract for health services. CMS notes that that section does not direct the issuer to treat the Indian as an “eligible insured,” and interprets this to mean that the limited cost-sharing reductions for designated providers are not limited to Indians eligible for a premium tax credit. CMS also interprets this section to apply only to the individual market inside the Exchanges.

Section 1402(d)(2)(B) of the ACA states that QHP issuers are not to reduce payments to the relevant facility or provider by the amount of any cost-sharing that would be due from an Indian but for the prohibition on cost-sharing. CMS believes it is impermissible for an issuer to reduce payments for any provider for any cost-sharing reductions required under the ACA, particularly because these cost-sharing reductions are to be reimbursed by HHS.

Provisions of part 156 related to Indians

CMS finalizes its proposal to use the concept of plan variations proposed for cost-sharing reductions for non-Indians to describe how Indians would pay none, or a portion, of the cost-sharing required under a plan, with the federal government bearing the remainder of the cost-sharing burden.

CMS finalizes the definitions and eligibility proposals including the previously described “zero cost sharing plan variation” of the expected QHP for those Indians with income at or below 300 percent of the FPL, and the previously described “limited cost-sharing plan variation” for all Indians for items and services provided by the IHS and other designated providers.

CMS reviews other policies set in part 156 and previously described in this summary and their applicability to QHPs serving Indians.

CMS sets out a formula for computing the monthly advance payment for cost-sharing reductions for the zero cost-sharing plan variation in a manner similar to that noted above for the silver plan variations.

Monthly PMPM advance payment =

Monthly expected allowed claims for the standard plan QHP in which the Indian is enrolled (Bronze, Silver, Gold, or Platinum),

multiplied by
 An induced utilization factor for the increased use at a higher AV with no cost-sharing (see table below)
 multiplied by
 The difference between the zero cost-sharing plan AV and the standard plan AV.

The induced utilization factors proposed by HHS are as follows, as presented in Table 24 in the final rule (78 FR 15495).

| From Table 24: Proposed Induced Utilization Factors for Computing Cost-Sharing Reduction Advance Payments for Indians | |
|--|-----------------------------------|
| Zero Cost Sharing Plan Variation | Induced utilization factor |
| Zero cost-sharing variation of Bronze QHP | 1.15 |
| Zero cost-sharing variation of Silver QHP | 1.12 |
| Zero cost-sharing variation of Gold QHP | 1.07 |
| Zero cost-sharing variation of Platinum QHP | 1.00 |

Regulatory Impact Analysis

CMS includes in its regulatory impact analysis a review of the impact of the rule related to advance payments of the premium tax credit and cost-sharing reductions. CMS expects that the proposed provisions will not alter CBO’s March 2012 baseline budget estimates of the budget impact of the two programs, as the proposals are well within the parameters of the modeling for the ACA.

CMS anticipates that the provisions will result in transfers from the general fund of the Treasury to people receiving cost-sharing reductions and advance payments of the premium tax credit. In table 26 in the final rule (78 FR 15515), it estimates that the annualized value of those transfers over the 2013-2017 period, in 2013 dollars, of \$6.5 to \$6.8 billion.

F. Provisions on User Fees for a Federally-Facilitated Exchange (FFE) (§156.50)

CMS reviews the ACA provisions for assessments or user fees to finance the activities of an Exchange in 2015 and subsequent years, along with existing federal policies regarding imposition of user fees.

CMS finalizes in §156.50(b) to require a participating issuer to make payments for user fees or other payments charges, or fees, if assessed by the state Exchanges. CMS finalizes in §156.50(c) that participating issuers operating through an FFE must remit a user fee to HHS each month. It clarifies in the final rule that the fee is equal to the product of premium set by the issuer for each policy offered through the FFE and the monthly user fee established by HHS in the annual notice of benefit and payment parameters.

CMS reviews the benefits to issuers of participating in the FFE. CMS finalizes the 2014 benefit year monthly user fee rate for the FFE equal to 3.5 percent of the monthly premium charged by the issuer for a particular policy under the plan.

G. Distributed Data Collection for the HHS-Operated Risk Adjustment and Reinsurance Programs (Subpart H)

1. Background

The Premium Stabilization Rule specifies at §153.20 that a risk adjustment methodology must include a risk adjustment data collection approach. As discussed above, HHS proposed and has now finalized a new §153.420(a) to establish that an issuer of a reinsurance-eligible plan must submit or make accessible all required reinsurance data in accordance with the reinsurance data collection approach established by the state, or by HHS on behalf of the state. In the proposed rule, HHS would have further amended Part 153 by adding Subpart H, entitled “Distributed Data Collection for HHS-Operated Programs,” in which it would clarify the data collection process that HHS would use when operating a risk adjustment or reinsurance program on behalf of a state.

HHS described a distributed approach as one in which each issuer formats its own data in a manner consistent with the risk assessment database, and then passes risk scores to the entity responsible for assessing risk adjustment charges and payments. HHS proposed that this approach would be used to collect data for the HHS-operated risk adjustment program and for the HHS-operated reinsurance program. The goal was to minimize issuer burden while protecting enrollees’ privacy.

Final Rule. HHS received a number of comments supporting this proposed approach. It has finalized the provisions of this section as proposed.

2. Issuer Data Collection and Submission Requirements

Under the HHS-operated risk adjustment and reinsurance programs, HHS proposed to use a distributed data collection approach to run software on enrollee-level and claims-level data that would reside on an issuer’s dedicated data environment. Close technological coordination between issuers and HHS would be needed.

The following proposed requirements would all apply to issuers of a risk adjustment covered plan or a reinsurance-eligible plan where HHS operated the risk adjustment program or reinsurance program on behalf of a state.

Distributed Data Environment and Timeline (§153.700). HHS proposed that for each benefit year in which HHS operated the risk adjustment or reinsurance program on behalf of a state, an issuer of the plan in the state would have to establish a dedicated data environment and provide data access to HHS, in a manner and timeframe specified by HHS. Such issuer would be required to establish secure, dedicated, electronic server environments to house medical and pharmacy claims, encounter data and enrollment information. The issuer would send the data to HHS in HHS-specified electronic formats and provide HHS with access to the data environment to install, update, and operate common software and specific reference tables to enable it to execute risk adjustment and program operations. Additional details would be specified in the future.

HHS proposed that it store, in a private and secure HHS computing environment, aggregate plan summary data and reports based on activities performed on each issuer's dedicated server environment. Except for purposes of data validation and audit, HHS would not store any personally identifiable enrollee information or individual claim-level information.

An issuer would have to establish the dedicated data environment (and confirm proper establishment through successfully testing the environment to conform with HHS standards for such testing) three months prior to the first date of full operation (e.g., for benefit year 2014, implementation, including testing, would begin in March 2013, and continue through October 2013, in preparation for the commencement of risk adjustment and reinsurance program operations on January 1, 2014). HHS planned to schedule technical assistance training for issuers in 2013.

Final Rule. HHS has finalized the provisions as proposed. In response to requests for clarification as to what information from the distributed data environments would be shared with states, HHS says that it is considering ways to provide states with information about HHS-operated programs, and welcome feedback about the types of summary information that would be most useful to states, mindful of its imperative to protect potentially sensitive information, including consumer health information. HHS will provide further information in subsequent guidance, as appropriate. In response to those requesting technical details about the distributed data environment, HHS notes that it has provided a list of required data for the HHS-Operated distributed data approach in the PRA package (See OMB Control Number 0938-1155). HHS will make available the data formats, definitions, and technical standards applicable to the HHS-operated distributed data approach in future guidance, including standards relating to data from chart reviews.

In response to comments requesting further clarification about the uses of data collected through the distributed data approach, HHS advises that it intends to provide further guidance on this issue but that data use will be consistent with HHS's commitment to protecting the privacy and security of enrollees. As a result, it would not store any personally identifiable enrollee information or individual claim-level information in connection with this data collection, except for the purposes of data validation and audit. HHS also notes that it will provide further details on model recalibration in future rulemaking and guidance.

Finally, in response to questions about the timeline and accuracy in the application of the distributed data approach, HHS says that it will work with issuers to establish robust systems. Issuers will have the opportunity to submit data files to a test environment. HHS will provide support for issuers who conduct such testing as well as provide ongoing support for the duration of the programs. As testing and implementation will be ongoing, HHS notes that an issuer must establish the dedicated data environment three months prior to full operation. More testing may still be needed. Further details and specifications for such testing will be provided in future guidance.

Enrollment, Claims and Encounter Data (§153.710). HHS had proposed to require that an issuer provide to HHS, through the dedicated data environment, access to the enrollee-level plan

enrollment data, enrollee claims data, and enrollee encounter data specified by HHS. In addition, all claims data submitted by an issuer in the state would have to have resulted in payment by the insurer. The enrollee-level data would have to include information from claims and encounter data (including data related to cost-sharing reductions, to permit HHS to calculate enrollee paid claims net of cost-sharing reductions) as sourced from all medical and pharmacy providers, suppliers, physicians, or other practitioners who furnished items or services to the issuer's health plan members for all permitted paid medical and pharmacy services during the benefit period. (Additional specifications related to reporting of encounters by capitated plans.) All data would have to be provided at the level of aggregation specified by HHS.

Final Rule. HHS has finalized these provisions as proposed with some clarifications. In §153.710(a) related to claims data, HHS requires that the claims that are submitted must have resulted in payment by the issuer (as it had proposed) but adds (“or payment of cost sharing by the enrollee”). HHS responds to a number of questions on nature of timing of data submissions, data storage, and other issues at 78 *FR* 15498-99.

Data Requirements (§153.710(a)). HHS had proposed that for risk adjustment, certain types of data would be acceptable for risk adjustment. The data collection period would encompass enrollment and services for the applicable benefit year. Institutional and medical claims and encounter data where the discharge data or “though date” of service occurs in the applicable benefit year would be allowed if: the types of claims, providers and diagnoses are acceptable. Issuers would be responsible for correcting errors and problems identified by HHS in the distributed data environment.

HHS proposed that data to identify eligible reinsurance paid claims would include medical and pharmacy claims. Claims that resulted in payment by the issuer as the final action and encounters priced in accordance with issuer pricing methodologies would be considered for payment.

Final Rule. HHS has adopted these proposals as final. It responds to a request for clarification on the acceptable provider types that diagnoses will only be acceptable for risk adjustment enrollee risk score calculations if they meet criteria that are acceptable for HHS risk adjustment data collection. HHS will release the full list of acceptable provider types and criteria in forthcoming guidance.

Establishment and Usage of Masked Enrollee Identification Numbers (§153.720). HHS had proposed that an issuer would be required to establish a unique masked enrollee identification number for each enrollee, in accordance with certain HHS-defined requirements and maintain the same masked number for an enrollee across enrollments or plans within the issuer, within the state, during a benefit year. Such an issuer would be prohibited from including an enrollee's personally identifiable information in the masked enrollee identification number or use the same identification number for different enrollees enrolled with the issuer.

Final Rule. HHS has finalized this provision as proposed. In response to a commenter's concern about the adequacy of privacy protections, HHS says that it has taken steps to ensure robust privacy and security standards. The distributed data approach protects consumer health data since it eliminates the need to transmit sensitive data. And HHS expects that information

provided to it will be limited to information reasonably necessary for use in the risk adjustment and reinsurance programs. Also, with this approach, HHS is better able to limit the amount of data needed for program operations. HHS will be releasing, in forthcoming rulemaking, compliance standards for privacy and security standards, as applicable.

Deadline for Submission of Data (§155.730). HHS had proposed to require an issuer to submit data to be considered for risk adjustment payments and charges and reinsurance payments for the applicable benefit year by April 30 of the year following the end of the applicable benefit year. States administering their own reinsurance program would have to notify issuers of reinsurance-eligible plans of their expected requests for reinsurance payments on a quarterly basis.

Final Rule. HHS finalizes the provision as proposed. It recommends that issuers submit data at least quarterly throughout the benefit year to support the calculation of reinsurance payments and risk adjustment payments and charges to that so that HHS can provide periodic reports on data functions performed in each issuer's distributed data environment. In response to a request for clarification on the penalty for non-compliant data submission, HHS says that compliance requirements are forthcoming. It notes that one consequence though of failing to timely submit claims and enrollment data would be that the information needed to calculate risk scores and reinsurance allowable amounts would not be available, potentially resulting in a loss of risk adjustment or reinsurance payments for the issuer. HHS also responds to requests for information on the claims run out period (see 78 FR 15500).

Information Collection Requirements for Reinsurance and Risk Adjustment

HHS had estimated for the proposed rule that fewer than 9 states would choose to operate their own risk adjustment and/or reinsurance programs. Collections from fewer than 10 persons are exempt from the PRA; thus HHS did not seek OMB approval for the related collections that it identified. However, if more than 9 states elected to operate risk adjustment in the future, HHS would seek PRA approval for these collections.

Final Rule. In §153.405, HHS has finalized the rules related to an annual enrollment count of covered lives by contributing entities using counting methods derived from the PCORTF Rule. HHS is requiring contributing entities to provide annual counts of their enrollment and remit reinsurance contributions to HHS based on that enrollment count. The work associated with this requirement is the time and effort required by an issuer or self-insured group health plan to derive an annual enrollment count. Because issuers or self-insured group health plans will already be obligated to determine a count of covered lives using a PCORTF counting method, the cost associated with this requirement is conducting these counts using the slightly modified counting methods specified in this final rule. In this final rule, HHS is modifying its estimate of the number of contributing entities from the proposed rule. HHS now estimates that 22,900 contributing entities will be subject to this requirement. On average, it will take an estimated 1 hour (at a wage rate of \$55 for an operations analyst) to calculate and submit final enrollment counts to HHS, for an aggregate cost of \$1,259,500 for 22,900 reinsurance contributing entities as a result of this requirement. HHS will revise the Premium Stabilization Rule Supporting Statement to include the required data elements that issuers or self-insured group health plans

will need to submit their annual enrollment counts in accordance with the counting methodology established in this final rule.

Costs to issuers required by final §153.720(a) for uploading risk adjustment and reinsurance data have been estimated in the final rule to be \$178 per year for an aggregate cost of \$320,706 for 1,800 issuers (HHS explains that the data submission requirements required by the Premium Stabilization Rule, which will result in additional costs to issuers (\$342,086 per issuer for an aggregate cost of \$621,754,800) are not costs due to the provisions of this final rule. It has amended the tables in this section of the final rule to account for the fact that these are not new incremental costs added by this rule.

Under §153.630(b), an issuer that offers at least one risk adjustment covered plan in a state where HHS is operating risk adjustment on behalf of the state must have an initial validation audit performed on its risk adjustment data. The cost associated with this requirement is the issuer's time and effort to provide HHS with source claims, records, and enrollment information to validate enrollee demographic information for initial and second validation audits and the issuer's cost to employ an independent auditor to perform the initial validation audit on a statistically valid sample of enrollees. For 1,800 issuers, HHS estimates that the total cost of conducting initial validation audits will be \$86.4 million. It will revise the information collection currently approved OMB Control Number 0938-1155 with an October 31, 2015 expiration date.

Under §153.630(d), issuers will have the opportunity to appeal errors identified through the second validation audit process. Because HHS intends to provide further detail on this process in later guidance and rulemaking, it cannot estimate the number of issuers that will appeal HCC findings, or the cost per issuer for doing so. Therefore, HHS will seek OMB approval and solicit public comment on the information collection requirements established under § 153.630(d) at a future date. (These and the other costs related to the Information Collection Requirements are shown in Table 25 at 78 *FR* 15513-4.)

Regulatory Impact Analysis for Risk Adjustment and Reinsurance

As noted in the impact analysis for the proposed rule, HHS believes that the CBO estimates of the budget impact of these ACA risk mitigation programs are the most comprehensive but it has updated them to reflect the four-year period from fiscal years (FYs) 2014 through 2017. Table 27, reproduced below, includes the CBO estimates for outlays and receipts for the reinsurance and risk adjustment programs from FYs 2014 through 2017. Unlike the current policy, however, CBO assumed risk adjustment payments and charges would begin to be made in 2014, when in fact they will begin in 2015. CBO did not separately estimate the program costs of risk corridors, but assumed aggregate collections from some issuers would offset payments made to other issuers. Table 27 summarizes the effects of the risk adjustment and reinsurance programs on the federal budget, with the additional, societal effects of this rule discussed in the regulatory impact analysis.

| Year | 2014 | 2015 | 2016 | 2017 | 2014-2017 |
|---|------|------|------|------|-----------|
| Reinsurance and risk adjustment program payments* | -- | 11 | 18 | 18 | 47 |
| Reinsurance and risk adjustment program receipts* | -- | 12 | 16 | 18 | 46 |
| * Risk adjustment program payments and receipts lag by one quarter. Receipt will fully offset payments over time. The CBO estimates do not reflect the \$5 billion in reinsurance contributions that are submitted to the U.S. Treasury. Source: Congressional Budget Office. 2011. <i>Letter to Hon. Nancy Pelosi</i> . March 20, 2010. | | | | | |

HHS further notes that risk adjustment, which transfers dollars from health plans with lower-risk enrollees to health plans with higher-risk enrollees, will result in a total of \$45 billion transferred among issuers from 2014 through 2017.

CMS anticipates that the cost of reinsurance contributions will be roughly equal to one percent of premiums in the total market in 2014, less in 2015 and 2016 (and ends in 2017)). It is anticipated that reinsurance payments will result in premium decreases in the individual market of between 10 and 15 percent.

H. Small Business Health Options Program (SHOP)

CMS finalizes proposed rules with modifications with respect to operations of the federally-facilitated Small Business Health Options Program (FF-SHOP), and at the same time issues a separate proposed rule (78 *FR* 15553-15558) to alter requirements for the Small Business Health Options Program.

1. Employee Choice in the Federally Facilitated SHOP (FF-SHOP)

Under the previously adopted rules for all SHOPS, a SHOP must allow an employer to select a level of coverage – bronze, silver, gold or platinum – and then provide for employee choice of QHPs within that level. A SHOP may provide for another method that allows employers to make one or more QHPs available to employees.

CMS modifies its proposed rule in response to comments and provides that a FF-SHOP would only permit the employer to:

- Offer employees a choice of all QHPs offering a single level of coverage (a single metal level); or
- Offer employees a single QHP selected by the employer.

CMS did not adopt an option to allow an employer to offer employees choices of QHPs at multiple metal levels because of initial concerns about adverse selection. CMS describes the option to allow employers in a FF-SHOP to make a single QHP available to employees rather than all QHPs in a metal group as a transitional policy. CMS notes that it made this choice in the context of the need, especially in the early years of implementation, to balance goals of employer

and employee choice with concerns about risk selection, achieving broad participation of issuers and plan designs, and effective competition in the small group market.

Importantly, in the proposed rule issued at (78 *FR* 15553-15558) CMS provides that each SHOP (not just the FF-SHOP) would have the option to delay implementation of employee choice and premium aggregation to begin on January 1, 2015 rather than January 1, 2014, and proposed that each FF-SHOP would exercise the January 1, 2015 delay option.

2. Methods for Employer Contributions in the FF-SHOP

In order for employees choosing coverage in the SHOP to know the net cost of each QHP to them after the employer contribution, the employer will need to choose a contribution level prior to the employee QHP selection process. CMS finalizes its proposal, with modifications, that a SHOP may establish one or more standard methods for employers to use in defining their contribution toward employee and dependent coverage.

With respect to the FF-SHOP, CMS will apply methods established in section III.G of IRS Notice 2010-82 pertaining to the small business premium tax credit as the initial methods available to employers in determining contribution amounts. These methods are referred to as “safe harbor” methods providing meaningful employer choice and conforming to federal law. The employer would choose a reference plan from among the QHPs offered in the level of coverage the employer is making available to its employees. The employer would then choose a percentage contribution toward employee-only premiums under the reference plan, and if dependent coverage is offered, a percentage contribution toward dependent coverage under the reference plan.

CMS has, however, eliminated its proposal to allow the employer to choose different percentages for different employee categories to the extent permitted under federal and state law, as it is inconsistent with previously established uniformity provisions in IRS Notice 2010-82, which require employers to contribute a uniform percentage to all employees in order to claim a small business tax credit. CMS notes that while the notice only applies to employers claiming the tax credit, the use of a uniform percentage for all employers helps assure that the employer contributions do not violate other anti-discriminate provisions.

Under the final rule, employers participating in an FF-SHOP could, except where prohibited under state law, vary contributions by employee age (or other permissible rating factor). Where state laws permit, employers would be asked whether they want each employee to contribute the same amount toward the reference plan premium, or whether they want the employee contribution to vary by age within the allowed (3 to 1) limits. CMS notes that with respect to tobacco use, the adjustment would always be applied as a surcharge to the employee premium.

In a case where the employer chooses to vary employee contributions by age, the employer contribution would be fixed and unaffected by employee decisions about participation. If however, an employer chooses to provide that each employee pay a fixed amount (and the employer contribution varies by age) the composite premium for the reference plan and the employer contribution would change based on which employees participate. In that case, once

employee choices were made the composite premium for the reference plan would be recalculated and the employer and employees notified of any changes. CMS also notes that the safe harbor approach for a FF-SHOP includes rating methods that are part of the IRS Notice including “list billing,” “composite billing” and “employer-computer composite rate.” IRS Notice 2010-82 is available at http://www.irs.gov/irb/2010-51_IRB/ar09.html#d0e533.

3. Linking Issuer Participation in an FFE to Participation in an FF-SHOP

Noting that a state-operated SHOP has more choices than an FF-SHOP to ensure a choice of QHPs and issuers, CMS finalizes, with one modification, requirements for certification of a QHP by the FFE that are linked to the issuer also offering coverage through the FF-SHOP..

Specifically, an FFE may certify a QHP for participation only if: 1) the QHP issuer offers through the FF-SHOP at least one small group QHP each at the silver and gold levels of coverage, or 2) the QHP issuer does not offer any small group plans in the state, but another issuer in the same issuer group offers at least one silver and one gold plan through the FF-SHOP, or 3) neither the issuer or any issuer in the same issuer group has a share of the small group market in the state greater than 20%. (CMS modifies the proposed rule by adding the specific 20% threshold in the final rule). An issuer group is defined to include issuers affiliated by common ownership and control and those affiliated by the common use of a nationally licensed service mark.

4. Broker Compensation for Coverage Sold Through an FFE or FF-SHOP

QHP certification for the FFE and FF-SHOP is conditioned on the QHP issuer paying similar broker compensation in the FFE and FF-SHOP to that paid for similar health plans outside the FFE and FF-SHOP. (Note: the preamble says the QHP must pay “similar” compensation but the regulatory text at §156.200(f), unchanged from the proposed rule, states that the QHP issuer must pay the “same” compensation. There is no explanation for this discrepancy.)

5. Minimum Participation Rate in the FF-SHOP

Under previously adopted rules, a SHOP may establish a uniform minimum participation rate for employee participation across QHPs offered in the SHOP, and in this rule, CMS finalizes a minimum participation rate for the FF-SHOP of 70%. The rate would be calculated as the number of qualified employees accepting coverage in the employer’s group health plan in a QHP in the FF-SHOP (not in an individual QHP) divided by the number of qualified employees offered coverage, excluding employees covered by a group health plan offered by another employer or a government program such as Medicare, Medicaid or TRICARE. This policy reflects CMS’ view that risk selection based on employee participation decisions is likely without a minimum participation rate.

CMS modifies the final regulatory text to reflect adoption in the Health Insurance Market Rule published in the *Federal Register* on November 26, 2012 the provisions at §147.104 that permit an issuer to limit enrollment of an employer to open enrollment periods if the employer fails to meet any minimum participation rate. Specifically, the final rule clarifies the provision at

§155.705(b)(10) that allows any SHOP to establish a minimum participation rate and the rule at §155.705(b)(10)(i) establishing the 70 percent minimum participation rate for an FF-SHOP are both subject to the requirements of §147.104.

The FF-SHOP can adopt a different uniform percentage for a state where the rate is set by state law, or a higher or lower rate is customarily used by the majority of QHP issuers in the state for products in the state's small group market outside the SHOP. CMS indicates that under the final rule, when an FF-SHOP makes the employee choice model available to qualified employers, it will use a consistent minimum participation rate across issuers.

6. Determining Employer Size for Purposes of SHOP Participation

CMS finalizes the amendment to the definitions of small employer and large employer previously adopted to specify the method for determining employer size using the definitions adopted for the employer shared responsibility requirements. CMS modifies the proposed rule to specify that the number of employees shall be determined using the full-time equivalent method set forth in section 4980H (c)(2) of the IRC rather than referencing 4980H(c)(2)(e) as in the proposed rule. The reason for the change in the final rule, in response to comments, is that the broader reference includes a counting provision that excludes certain seasonal employees when determining if an employer is subject to the shared responsibility payment, and CMS determined that it was a more appropriate calculation for purposes of participation in a SHOP. The definitions are effective for plan years beginning on or after January 1, 2016 except for the operations of an FF-SHOP, for which it is effective for plan years beginning on or after January 1, 2014 and in connection with enrollment activities beginning October 1, 2013.

Under the previously adopted definitions, a small employer is one who, in connection with a group health plan with respect to a calendar year and a plan year, employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. In the case of plan years beginning before January 1, 2016, a state may elect to define small employer by substituting "50 employees" for "100 employees." A large employer means one who employs at least 101 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. In the case of plan years beginning before January 1, 2016, a state may elect to define large employer by substituting "51 employees" for "101 employees."

7. Definition of a Full-Time Employee for Purposes of Exchanges and SHOPS

CMS notes that the ACA defines a qualified employer as one that elects to make all full-time employees eligible for QHPs in the small group market through an Exchange. It does not define a full-time employee for this purpose. In this rule, CMS cross references section 4980(H)(c)(4) of the Internal Revenue Code which defines a full-time employee with respect to a month generally as one who is employed an average of 30 hours of service per week. (Additional rules apply, including those with respect to employees who are not compensated on an hourly basis.) This definition is effective for plan years beginning on or after January 1, 2016 except for the

operations of an FF-SHOP, for which it is effective for plan years beginning on or after January 1, 2014 and in connection with open enrollment activities beginning October 1, 2013.

8. Transitional Policies

With respect to the definitions of small employer and full-time employee discussed above, CMS recognizes that states employ definitions and methods of counting employees that differ from those set out in the rule, and that the ACA gives states discretion in defining the small group market in 2014 and 2015. Therefore, while CMS will use the definitions for the FF-SHOP effective October 1, 2013, they are effective on January 1, 2016 for purposes of Exchange and SHOP administration. No enforcement action will be taken by HHS against a state-operated SHOP for including a small employer based on a state definition if the group would have been a large employer under the federal definition, and during 2014 and 2015 an employer and a state-operated SHOP may adopt a reasonable basis for determining whether coverage has been offered to all full-time employees. CMS notes that the proposal did not address application of state-specific definitions or counting rules that would exclude a small group health plan from protections provided under federal law.

CMS notes that because the FF-SHOP will use the proposed federal definitions including full-time equivalent employees, there may be a few employers who could purchase small group coverage outside the FF-SHOP under state definitions yet be ineligible for the FF-SHOP.

9. Web site Disclosures Relating to Agents and Brokers

Previously adopted rules allowing Exchanges to elect to provide for website disclosure of information regarding licensed agents and brokers are modified to allow an Exchange or SHOP to limit the display to include only those agents and brokers who have completed an Exchange or SHOP registration or training process. FFEs and FF-SHOPs will limit disclosure to agents and brokers who have completed registration and training. CMS believes that listing only those brokers that have registered with the Exchange is in the best interest of consumers, because the registration and training will help ensure that the agent or broker is familiar with Exchange policies and application procedures. In addition, it will avoid the website listing large numbers of inactive agents and brokers.

10. QHP Issuer Standards Specific to SHOP

CMS modifies the standards at §156.285 to require that QHP issuers participating in a SHOP must enroll qualified employees if they are eligible for coverage. This change is intended to align SHOP enrollment standards with those for the Exchange.

11. Information Collection Requirements, Regulatory Impact Analysis and Other Requirements

With respect to employee choice in the SHOP, CMS notes that the provision to permit the FF-SHOP to allow employers to offer only a single QHP to enrollees is designed to reduce adverse

selection, but it has not quantified the “small risk premium” or “modest consumer benefit” associated with the employee choice option.

CMS discusses the benefits associated with providing greater consumer choice, and identifies that additional impacts include the costs to issuers of submitting plans for certification to the FF-SHOP and user fees for additional enrollees in QHPs in the SHOP.

The regulatory impact analysis estimates that the requirement for a 70 percent uniform minimum participation rate for the FF-SHOP, with exceptions based on state law and issuer practices, will not change market dynamics or place any additional costs on employers or issuers.

Under the Regulatory Flexibility Act, CMS provides an analysis of the effect of the final rule on small entities. CMS does not believe the rules impose requirements on employers offering coverage through the SHOP that are more restrictive than current requirements on employers offering employer-sponsored health insurance coverage.

I. Medical Loss Ratio Requirements

Under the Medical Loss Ratio (MLR) requirements, issuers must rebate a portion of premiums for a year if their MLR does not meet the minimum standard for that year. The MLR is calculated as claims plus quality improvement activities divided by premium revenue. Revenue is adjusted for taxes, regulatory fees and the premium stabilization programs.

CMS finalizes with modifications its proposals to modify and correct MLR regulations that were adopted in a final rule with comment period published in the *Federal Register* on December 7, 2011 (76 *FR* 76574). The final rule: modifies the MLR calculations to take into account payments to and receipts from the premium stabilization programs; changes the reporting and rebate deadlines beginning with 2014; and limits the deduction from premium for community benefit expenditures. In addition, errors in previously adopted regulations are corrected.

Treatment of Premium Stabilization Payments

CMS adopts, with modification, the proposed definitions used in calculating the MLR beginning with the 2014 MLR reporting year to take into account premium stabilization payments. The proposed rule would have considered all premium stabilization amounts as part of total premium revenue reported to the Secretary, but removed them from the adjusted earned premium so that they do not have a net impact on the calculation of the MLR denominator and rebate amounts. In addition, under the proposed rule, all premium stabilization amounts would be an adjustment to incurred claims in calculating the MLR numerator.

The final rule adopts the proposal for premium stabilization amounts other than reinsurance contributions. That is, risk adjustment amounts, risk corridor amounts, and reinsurance payments will have a net impact on the MLR numerator as proposed. However, in response to comments, CMS modifies the final formula to treat reinsurance contributions as fees or assessments deductible from premium in MLR and rebate calculations. Additional clarifications are made to the rebate calculation example in regulatory text, in response to comments.

In response to comments, CMS agrees that risk adjustment user fees are deductible from premium in MLR and rebate calculation. CMS does not agree with some commenters that expenditures on risk adjustment data validation systems or other operational costs related to premium stabilization programs constitute a regulatory fee or assessment or a premium stabilization program transfer.

The formula for calculating MLR follows:

$$\text{Adjusted MLR} = [(i + q - s + n - r) / \{(p + s - n + r) - t - f - (s - n + r)\}] + c$$

Where,

i = incurred claims

q = expenditures on quality improving activities

p = earned premiums

t = Federal and State taxes and assessments

f = licensing and regulatory fees

s = issuer's transitional reinsurance receipts

n = reinsurance, risk corridors, and risk adjustment payments made by issuer

r = issuer's reinsurance, risk corridors, and risk adjustment related receipts

c = credibility adjustment, if any.

Rebates for a company whose adjusted MLR value for a market in a state falls below the minimum standard will be calculated using the following formula, reflecting proposed changes:

$$\text{Rebates} = (m - a) * [(p + s - n + r) - t - f - (s - n + r)]$$

Where,

m = the applicable minimum MLR standard for a particular State and market

a = issuer's adjusted MLR for a particular State and market.

Reporting Deadlines

CMS finalizes its proposal to change the deadlines for MLR reporting and rebates in order to conform to the premium stabilization program reporting cycles. Beginning with the 2014 MLR reporting year, the deadline for MLR reporting to the Secretary will be changed from June 1 to

July 31, and the rebate due date will be moved from August 1 to September 30. Rebates provided as a credit must be applied to the first month's premium that is due on or after September 30 following the MLR reporting year, and any overage applied to succeeding premiums until the full rebate has been credited.

Deduction of Community Benefits

CMS makes changes with respect to the treatment of community benefit payments made by tax exempt issuers in the MLR calculation. First, an issuer exempt from federal taxes may deduct both state premium taxes and community benefit expenditures from earned premium in the MLR calculation. In making this change, CMS agrees with commenters that community benefit expenditures are a requirement for maintaining federal tax exempt status and therefore should be treated in the same manner as the federal income tax payments made by for-profit issuers, which are deducted from earned premium. Second, the limit on community benefit expenditures is modified to be either 3 percent of the issuer's earned premium or the highest premium tax rate charged in the state multiplied by the issuer's earned premium in the applicable state market, whichever is greater. The rule does not amend previous provisions that permit an issuer that is not exempt from federal income tax to deduct the higher of their state premium taxes or their community benefit expenditures limited to the highest premium tax rate charged to an issuer in the state. CMS notes that the amount of community benefit expenditures deducted may not exceed the amount of actual community benefit expenditures in the reporting year.

CMS also adopts proposed technical changes to correct several errors in previously adopted MLR rules and earlier corrections. These amend §158.140 and §158.232. In responding to comments, CMS notes that it will continue to consider the need to issue clarifying guidance with respect to the various accounting and actuarial elements affecting the MLR and rebate calculations.

Information Collection Requirements

Prior to the deadline for issuer submission of the annual MLR report for the 2014 MLR reporting year, HHS plans to solicit public comment and seek OMB approval for an updated annual form that will include reporting of the premium stabilization payments and reflect the changes made in the deduction for community benefit expenditures for federal income tax-exempt issuers.

Regulatory Impact Analysis

The adjustments in the MLR calculations will increase or decrease insurers' MLRs and could therefore also increase or decrease consumer rebates. CMS does not have data to estimate which issuers have high-risk enrollees and therefore will have positive net premium stabilization payments and higher MLRs under the changes. CMS estimates that, based on data from the 2011 MLR reporting year, 466 issuers offering coverage in the individual and small group markets to almost 80 million enrollees will be affected by the proposed changes. Reported rebate payments made in 2012 are shown in the table below. Again, no estimates are available on how rebates may be affected by the MLR calculation changes in this rule. The administrative costs of reporting premium stabilization amounts in the MLR report are considered to be minimal.

| MLR Rebates Made in 2012 (for 2011 MLR Reporting Year) | | | |
|---|--------------------------|------------------------------------|--|
| Market | Number of Issuers | Total Rebates (in millions) | Number of Enrollees (in millions) |
| Individual | 54 | \$396 | 4 million |
| Small group | 59 | \$289 | 3 million |
| Large group | 47 | \$403 | 6 million |
| See: 78 <i>FR</i> 15521-2 | | | |

With respect to the changes to deductibility of community benefit expenditures, CMS estimates that based on data for the 2011 MLR reporting year, 132 issuers will be affected. Because community benefit expenditures are estimated to be below the current limit as well as the proposed limit, the proposed change is estimated to have minimal effect on MLRs and rebates.